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LA GRIPPE; ITS CHARACTERISTICS AND TREATMENT.

BY EDWARD ANDERSON, M. D.,
ROCKVILLE, MD.

This disease has been among us for years and it seems to have come to stay, for there is scarcely a day that I do not see persons suffering from it, either in the acute or chronic form. It is chiefly characterized by the contracted condition of the arterioles. In the acute form the brain suffers more than any other part, for its arteries are less capable of resistance than those situated elsewhere—the heart not having lost its force, the brain receives an undue amount of blood and hence that sense of fulness, accompanied by throbbing pain that is so often felt. When la grippe first made its appearance, apoplexy was not a very uncommon accompaniment. Knowing the nature of the malady, we should employ such remedies as have the power of relaxing the terminal arterial branches and removing the strain from the overtaxed heart. Where such remedies are not resorted to, this complaint becomes chronic, the vessels remaining permanently contracted. Rest in bed until complete recovery takes place, with sufficient covering to make the skin act freely, is of great importance in an acute attack. After giving a dose of calomel, I always prescribe salicylate of sodium, both in the acute and chronic forms of this disease. It puts an end to any pain that may be present and relieves the embarrassed circulation at once. Alcohol and many other drugs possess the power of dilating the smaller blood vessels and of

determining the blood to the surface, as is evidenced by the free perspiration often following their use, but I prefer salicylate of sodium to anything else.

When la grippe first made its appearance among us, it was generally accompanied by high temperature, but now it is usually low, 95° F. not being very uncommon.

A boy of seventeen came to me a few days ago whose temperature was 94.5°F., and whose pulse was sixty to the minute. I gave him fifteen grains of salicylate of sodium three times daily; in a few days his pulse and temperature were normal. Three years ago, a gentleman residing in the upper part of our county came to Rockville on business. On attempting to get into his vehicle to return home he found he was unable to do so on account of a bursting headache, and great prostration. The thermometer in his mouth registered 95°F., but his appearance indicated a temperature of 104° F. I gave him thirty grains of salicylate of sodium, and in an hour he was able to drive to his home, a distance of eighteen miles. Many physicians, when they find the pulse weak and the temperature low, are in the habit of treating these cases with tonics, but in my opinion it is the worst plan they could pursue, as there is always enough, if not too much, appetite for their enfeebled digestion. Last summer a gentleman of sixty-five put himself under my treatment. When I first examined him, his pulse was intermittent and almost imperceptible; he looked as if he might die at any moment; I put him on seven and a half grain doses of sodium taken in a teaspoonful of essence of pepsin, three times daily, with an occasional dose of digitalis. His heart action became regular on the second day and the greatest improvement in his condition took place. This patient was on iron, quinine and strychnine when he came under my care; he was getting worse all the time. This was a case of chronic grippe. I have seen many others like it and treated them in the same way and with the same result.

LARGE DOSES OF STRYCHNINE IN THE TREATMENT OF PULMONARY AND CARDIAC DISEASES.*

BY THOMAS J. MAYS, A. M., M. D.,
Professor of Diseases of the Chest in the Philadelphia Polyclinic, and Visiting Physician to the Rush Hospital for Consumption.

From quite an extended experience with the use of strychnine I feel convinced that this drug gives better practical results in the treatment of pulmonary and cardiac diseases than any other single remedy at our command, and it occurred to me that a short discussion of the principles which I have followed in its administration might be of interest to the members of this Society.

It is needless to tell you that strychnine has a more powerful stimulating influence over the nervous system than any other drug in the materia medica, and that besides its general action it has a special influence on the nerve supply of the lungs, heart, stomach, intestines, etc. Now, without going into details, it is my belief that many affections of the lungs and heart are fundamentally dependent on disorders of the nerves which supply these organs, and that the curative effects of this agent in

*Read before the Philadelphia County Medical Society, September 27, 1893.

these diseases rest largely on the power which it has in correcting this primary aberration. Over and above this, it has been recently shown that strychnine also has the faculty of multiplying the corpuscular elements of the blood, and is therefore, like iron, a blood-builder. A combination of such valuable properties in a single agent makes it apparent on theoretic grounds alone why strychnine should possess such a beneficial therapeutic effect in the diseases which we are here considering, since anæmia is one of their most common complications. In spite of these desirable qualities I believe that we often fail in obtaining its best effects by giving it in doses which are entirely too diminutive. I do not mean to say that strychnine should be given in large doses in every disease to which it is applicable, for such a statement might lead to great harm if it were practically carried to its legitimate end, but these remarks pertain only to those diseases to which reference is made in this paper. The custom of giving strychnine in doses of 1-60 or 1-50 of a grain I have discarded long ago, for I feel satisfied that such amounts are comparatively worthless. It is very rare that I begin with a smaller dose than 1-32 of a grain, and more often with 1-30 of a grain, and then gradually increase in an ascending scale until I touch the limit of toleration. Strychnine is peculiar in this respect. The length of the ascending scale from the effects of such a dose to a point where the physiological action of the drug begins to develop itself is usually very long, and during the time that this is traversed by the therapeutist a free opportunity is given in which to obtain the full stimulant action of the drug in gradually increased doses. I usually incorporate one grain of strychnine with phenacetin, quinine, etc., and divide the whole into thirty-two capsules, and give one capsule four times a day. This lasts eight days, and then 1-8 of a grain more of strychnine is added to the whole quantity, which is thereafter increased 1-4 of a grain every eighth day until the limit of toleration is approached. This varies very much in different individuals. I have a number of patients under my care at the present time who are taking 1-10 of a grain, four who are taking 1-7 of a grain, and one who is taking 1-6 of a grain four times a day. Most of these patients have been taking the drug from three to seven months continuously. I have seen patients, however, who could not endure more than 1-20 of a grain four times a day. So soon as a patient begins to show signs of intoxication the dose is reduced to a point where this is no longer manifested, and then maintained there permanently or again increased after some time. It is possible, however, and this should always be borne in mind, that the dose which was toxic once may in time be taken with impunity. This would seem to show that the poison line of strychnine recedes, and that the drug establishes a certain degree of tolerance for itself. Yet I have met with one case where the administration of the drug was broken off for almost two weeks, and then, on resuming the same dose which was previously taken, marked rigidity of the lower limbs followed after the first two doses.

What, if any, are the untoward effects of strychnine when given in such large

doses? So far as I know, there are none except its occasional tendency to produce diarrhœa; but at the very worst I do not believe this proneness is very pronounced. In my earlier acquaintance with it I fancied that it aggravated the diarrhœa which is such a frequent accompaniment of phthisis, but my later experience fails to confirm this, since I have seen cases of intestinal tuberculosis get well when strychnine was given in combination with morphine and oxide of zinc. It has been asserted that it causes albuminuria by reason of the high blood tension which it brings about. Of this I have not observed the least evidence, having frequently examined the urine of patients to whom strychnine had been administered in such large doses for more than a year.

I will now briefly consider in detail the mode of giving strychnine in each disease to which it is believed to be applicable. In *asthma* I usually begin by introducing about 1-20 of a grain under the skin, and administer about 1-30 or 1-25 of a grain by the mouth four times a day, and gradually increase this in the way above indicated. Hypodermatically it is given once a day or every other day, and, if possible, in the evening, until there is an approach to the production of the toxic effects of the drug. Suitable doses of phenacetin, quinine, capsicum, and ammonium muriate will enhance its action. So far as my experience goes, strychnine must be regarded as the most powerful adjuvant in the treatment of asthma, although we must never lose sight of the importance of treating the diathesis or exciting cause on which the disease often rests, and also of improving the general nutrition.

Bronchitis, whether acute or chronic, is very much benefited by strychnine. It checks the cough, diminishes the expectoration, improves the appetite and puts to one side the whole constitutional relaxation and feebleness frequently present, especially in the chronic form of this disease. It must be given in ascendant doses, and may be combined with benefit with the syrup of the hypophosphites or hydriodic acid, or with both.

Strychnine is one of the most useful agents in treating acute pneumonia, whether this is of the croupous or catarrhal variety. I usually begin by injecting 1-20 of a grain, and if the case is severe I keep this up morning and evening, together with the internal administration of 1-20 of a grain every three or four hours until symptoms of intoxication begin to show themselves. This I have seen to take place on the second and third day of the disease. If the case is a mild one it will suffice to give 1-20 of a grain every four hours.

I know of no disease which is more eminently benefited by strychnine than pulmonary consumption. Indeed, as a rule, it seems that sufferers from this disease are capable of taking this drug in extraordinary large doses. I have a number of phthisical people under my care at the present time, both in hospital and in private practice, who are taking over half a grain of it a day—a dose which had been reached by a gradual increase of a smaller one. For a more complete description of the use of strychnine in primary pulmonary diseases I would refer you to a paper of mine on this subject, contained in *The Medical News* of July 22, 1893, and the remainder of this paper will be devoted to a consider-

ation of the application of this drug to cardiac and cardio-pulmonic diseases.

In recommending strychnine as one of our most valuable cardiac stimulants a fear may spring up in the minds of many that this drug is put forward for the purpose of displacing digitalis—the old and well-tried heart tonic. That such a suspicion is not altogether groundless when held by those who prescribe digitalis for almost every phase and form of heart disease they meet, is true; but he who looks the question of cardiac therapeutics squarely in the face, feels, although more perhaps from an instinctive than from a scientific standpoint, that the action of digitalis is not interchangeable with that of strychnine, and that each fulfils its own peculiar indication in the treatment of diseases of the heart. Although we may not be able to draw a rigid line of demarcation between the behavior of these two agents, we have experimental evidence to show that digitalis acts more on the muscular and less on the nervous structure of the heart than strychnine. My own experiments demonstrate that digitalis enhances or increases the irritability of the heart muscle, while strychnine depresses or reduces it; and that the former arrests the heart in systole while the latter arrests it in diastole. It is my belief that the action of these drugs is as dissimilar clinically as it has been shown to be physiologically, and that strychnine is principally indicated in those diseases of the heart which are dependent on a disturbance of innervation, as for example, in simple cardiac weakness and in irregularity and intermittency of its pulsations, while digitalis is preferable in cases where there is a want of compensatory power in the heart muscle, as in valvular incompetency.

Bearing in mind this difference, strychnine should be prescribed when the nerve supply of the heart is enfeebled through auto-intoxication, such as is found in the post paralysis of diphtheria, scarlatina, measles, smallpox, influenza, whooping-cough, and in poisoning from alcohol, lead, mercury, etc.

Irregularity and intermittency of the heart's action are frequently benefited by the administration of large doses of strychnine, and more often than not do we find that digitalis is utterly useless in such cases. Sometimes the irregularity will remain even under the influence of strychnine, but the symptoms which are dependent on or are a part of this condition, such as pain in the precordium, orthopnœa, oppression of the chest, will improve or disappear, especially if suitable evacuant remedies are used at the same time. This whole disorder I regard as being probably due to a want of power in the discharge of nerve-force of the heart or rather, perhaps, to a lack of nerve control over the discharge of the muscle force of the heart. This weakness of nerve power is not only marked in the heart, but it is also apparent in the lungs and frequently manifests itself especially in elderly people, in a co-existent œdema of the bases of both lungs.

Morever, there is often found an irregularity or intermittency of the heart's action in severe seizures of asthma, and I know of nothing which will remove this accompaniment, as well as the original disease, as strychnine in large doses promptly administered, both hypodermatically and by the mouth.

Angina pectoris is another paroxysmal disease in the treatment of which strychnine in large doses stands pre-eminent.

Again, digitalis is always regarded as

the sovereign remedy in the treatment of valvular diseases of the heart and their sequences, but there comes a period in the life-history of every such affection in which digitalis, no matter how much benefit was derived from it before, proves utterly useless. This leads of course to disappointment, and often gives rise to serious suspicion concerning the utility of this important agent. The fault lies, however, not in the drug, but in its improper application. It has done all that could reasonably be expected of it. It stimulated the heart-muscle to renewed activity after the valvular rupture occurred. It aided in developing its muscular fibres and restored its former power; but now, for some reason or other, the nervous energy of the patient begins to flag, and the heart-walls commence to relax in spite of the muscular hypertrophy which is present, and digitalis no longer possesses the spurring properties which it once had. The blood dams up in the left ventricle and auricle, the pulmonary circulation becomes impaired, œdema and congestion of the lungs follow, and death is threatened by way of the pulmonary organs. It is at such a time, when digitalis fails to counteract these many incidental complications, that strychnine steps in and shows its superior value as a tonic to the waning nerve energy of the heart and lungs.

PLEURAL EMPYEMA OPENING AT UMBILICUS.

Some weeks ago I was called to see a child, aged 18 months. I found a free flow of pus from the centre of the umbilicus. I was told that it had burst quite suddenly that morning. Examination of the abdomen revealed nothing. The parents told me that the child had been suffering from bronchitis and pleurisy some weeks previously, and I found evidence of fluid in the left pleura. To confirm this diagnosis I made an exploratory aspiration between the fifth and six ribs on the left side and drew off a syringe full of pus. The discharge continued to flow freely from the umbilicus for three or four days and then ceased. By this time all signs of fluid in the pleural sac had disappeared, and the child made a good recovery. The exact course which the pus pursued in its journey from the pleural sac to the umbilicus is difficult to trace, but most likely it found its way out of the thorax through the interval caused by the deficiency of muscular fibres in the attachment of the diaphragm to the ensiform cartilage. As I cannot find a similar case quoted in any of the standard works on medicine at my disposal, I take it to be a very rare occurrence.—Dr. Willis, in *Brit. Med. Jour.*

According to Winternitz, the quantity of toxines contained in the urine, in typhoid fever, is increased six or eight times by means of a cold bath, indicating that by the application of cold, in some way, there is an increased elimination of these poisonous matters from the body. This may possibly be connected with the fact that, as has been shown hy Winternitz, the application of cold to the part results in an accumulation of leucocytes.—*Med. Review.*

In dyspnea attendant upon some chronic disorders, phosphorus in minute doses often gives satisfactory relief.—*Ex.*

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BALTIMORE, OCTOBER 28, 1893.

Editorial.

OUR LOCAL MEDICAL SOCIETIES.

Baltimore is fortunate in having some six or seven local medical societies, well organized and with large membership, representing the larger number of practitioners in the city. After a recess of three months these societies have renewed their regular sessions for the fall, winter and spring months. It may not be out of place at this time to refer to the importance of the work before each of these organizations and to call attention to the necessity of giving proper support to the work which each society has in view. No one can view the growth of the profession in this city without realizing that the local society is not only a stimulus to higher and better work in medicine, but that it is the most efficient means of professional organization within the reach of medical men.

These two purposes alone should commend the local society to professional support.

In the relation of cases, preparation of papers, exhibition of specimens and general discussion, the society offers a valuable field for the exercise and development of medical knowledge and experience. It is not necessary that this work should always attain the highest standard of originality. If the work is carefully and conscientiously done it is a stimulus to higher effort and an incentive to better performances upon subsequent occasions. To the younger members of the profession there can be no loss in the effort which he puts forth to improve his own attainments and to instruct his seniors. Both labor and time are well employed in a study of cases or preparation of papers. He has an advantage in having time for study and reflection in the preparation of material which he offers for the consideration of his brother members. To the older and busier members the opportunity for good work cannot be questioned. These men are in active practice, which brings them in daily contact with a large clinical experience. They see and treat disease and accident in their varied forms and meet with conditions which tax the art and science which they daily practice. This material and this experience should not go to waste. When properly presented to other minds it adds to their larger knowledge and experiences. The busy practitioner is too prone to claim that his exacting duties will not admit of his participating in the work of the medical society. He is too willing to rest at home after the work of the day, or to seek relaxation in society or at the theatre in preference to an attendance upon a medical meeting.

At least such is the habit with many of our busiest men in this city. We can not but believe that force of habit is largely responsible for this condition of affairs. An examination of the proceedings of the local societies of other large cities in this country and in Europe reveals the fact that the major part of the work is done by the older and hardest-worked men. Such busy men as DaCosta, Goodell and Pepper, of Philadelphia; Thomas, Polk and Loomis, of New York; Sir Spencer Wells, Sir James Paget and Bantock, of London; and Virchow, Martin and Koch, of Berlin, find time to do much work in the medical organizations of their respective cities.

If, however, the busy practitioner of our city cannot be induced to take part in the work of the local society, there is all the more reason for constant and prompt attendance upon the part of the younger members. The local society has come to stay and it should call forth the warm-hearted support of our profession. We look forward to a winter of unusual activity and interest in the work of the medical societies of Baltimore.

THE STATE APPROPRIATION TO CITY HOSPITALS.

Up to 1886 there was not a hospital in this city which provided free beds to the indigent sick of the counties. For years past the city had supported a large number of free beds in our largest hospitals and it only now and then happened that an unfortunate individual from one of the counties gained admission to the hospital through a free bed supported by the city.

In 1886 the Maryland General Hospital obtained an annual appropriation from the Legislature of $3700 which enabled this institution to furnish one free bed to each of the counties and two to each of the three Legislative districts in the city. Prior to that time the indigent sick in the counties were cared for in jails and almshouses or were dependent upon the charities of friends or relatives who, oftentimes, were unable to provide them with necessary food and attention. There was not only much suffering among this class of invalids, but many with curable diseases were kept incurable for want of necessary treatment. The burden upon the taxpayers of the counties was necessarily heavy from the fact that the facilities for providing for these people were inadequate and the service required for their support was expensive. The Maryland General Hospital very soon demonstrated that most excellent work could be done for this class of people, and it so popularized this feature of State charity that other hospitals were prompted to go before the Legislature and ask for similar privileges. The Legislature subsequently granted appropriations to the City, Maryland University and Good Samaritan Hospitals upon conditions similar to those which prevailed at the Maryland General Hospital.

At the present time these institutions annually treat a large number of the sick and infirm poor from the counties. No worthy case is refused admission to any of these hospitals. Up to the present time this system has worked well, and it has had the very practical effect of relieving the county jails and almshouses of incurable cases, many of whom have been so successfully treated as to be-

come bread-winners and useful citizens to the State.

The amount annually contributed by the State for this useful work is small in comparison with the results which flow from the appropriation.

Apart from the benefit which is conferred upon these people by these institutions, the assistance rendered to the hospitals is a very positive advantage in the way of support and in the maintaining of clinical material for bed-side instruction. All of the hospitals named are connected with medical schools which attract large classes of students to the city. These young men spend annually thousands of dollars for board, instruction and incidentals, and this money indirectly contributes to the prosperity of the State.

As a mere business investment the State is materially profited by her liberality. We do not hesitate to say that she could well afford to double her annual appropriation to these hospitals and then make a handsome profit by her investment.

It is understood that Governor Brown is especially interested in this subject and that he will embody his views on the subject of State Charities in his forthcoming message to the Legislature. Governor Brown is a broad-minded and public-spirited Executive and we feel assured that he will view this subject from a standpoint that will illustrate the value of the work the hospitals named are doing for the sick poor of our State.

AN EDITORIAL APOLOGY.

The art of writing, like the art of public speaking, becomes awkward to one who is out of practice.

It requires constant work to present one's ideas in smooth and correct sentences. The present editor of the JOURNAL labors under the disadvantage of having been absent from the editorial chair for some six years. With other pressing duties demanding his time and thought, he finds it no easy task to collect material for a weekly publication.

That errors of composition and of expression will happen to him is scarcely avoidable, but he wishes to disclaim against the mistakes of the proof-reader, which have added to his own short-comings.

As he is only temporarily in charge of the JOURNAL until a more fitting editor can be selected by the publishers to occupy the vacant chair, he asks the JOURNAL readers to deal leniently with his efforts for the time being.

Reviews, Books and Pamphlets.

THE NEW PHARMACOPŒIA.*

This revised volume is interesting, not only as fixing the fulness and the limitations of our most reliable drug resources in an authoritative way; but as furnishing a criterion by which we may estimate the advances of the past decade in this department of the great calling of medicine.

The additions to our lists of useful drugs are about equalled in number by the omissions of old drugs found to be unworthy of official sanction. Among

*The Pharmacopœia of the United States of America. Seventh Decennial Revision (1890) by Authority of the National Convention for Revising the Pharmacopœia, held at Washington, 1890. Official from January 1, 1894. Published by the Committee of Revision. Philadelphia: Printers and Binders, J. B. Lippincott and Co. Agents, P. Blackiston, Son & Co. 1893.

those added are several which are unfamilar to the great mass of practitioners; but likewise several which are destined to play an important part in the therapeutics of the future. Among these are cocaine, acetanilid, caffein citrat, eucalyptol, hyoscinæ hydrobromat, menthol, oil of cade, paraldehyde, pepsin, resorcin, salol, sodium nitrate, spartein sulphat, strontium bromide, and strophanthus. Although greater progress might be desired, this list is by no means to be despised, since it represents agents of decided power for good whose virtues have been carefully tested. Among them, cocaine is the most remarkable, possessing virtues of a character quite unique in their efficiency and general applicability —virtues the development of which have led to a revolution in certain fields of minor surgery.

The stand which the compilers have taken against the introduction, and so endorsement, of "any substance which cannot be produced otherwise than under a patented process or which is protected by proprietary rights" is in our opinion a wise measure.

The self-control which the authors have shown in refraining from tinkering with the names and terminations of familiar drugs will be gratefully remembered by the practitioner. Such changes as *have* been made in this line are wholly commendable.

Strong pressure was brought upon the authors to induce them to fix the strength of standard preparations by assay of the active ingredients. It was found however that a general application for this rule would involve too great difficulties, even leading to complications in suits at law. In only three instances therefore are assay standards established —for cinchona, nux vomica and opium.

It was not found advisable to bring all tinctures, as suggested, to a uniform strength of 10 per cent. The strength of some eighteen tinctures was changed, the three opium tinctures being now slightly stronger, but in no case are the changes sufficiently great to cause danger.

The metric system of weights and measures is used.

The term "Emulsum" is introduced in the place of "mistura" to designate certain liquid preparations which are really emulsions.

Minor Surgery and Bandaging. By HENRY R. WHARTON, M. D., Demonstrator of Surgery in the University of Pennsylvania. In one 12mo. volume of 529 pages, with 416 engravings, many being photographic. Cloth, $3.00. Philadelphia: Lea Brothers & Co., 1893.

In the 500 pages of this work the author treated in clear and concise manner not only the subject of minor surgery and bandaging, but also gives short articles on tracheotomy, intubation, ligation of arteries and amputations. The style of the work and print is in the usual good style of the publishers. The work can be well recommended as a textbook to students and practitioners.

Saunders' Question-Compends; Essentials of Minor Surgery, Bandaging and Venereal Diseases. 82 illustrations. By EDWARD MARTIN, M. D. Price $1.00. Philadelphia: W. B. Saunders, 1893.

This book is arranged in the form of questions and answers and is especially prepared for the use of the student,

After the student has acquired the necessary knowledge of minor surgery, and skill in applying bandages by attending the clinics and demonstrations and by practical work, for which there is ample provision made in many of our medical colleges, he will find the "Question Compend" a help.

Transactions of the Medical Asssociation of Georgia; Forty-fourth Annual Session. 1893. Atlanta, Ga.; Published by the Association.

Transactions of the American Pediatric Society; Fourth Session, held at Boston, Mass., May 2, 3 and 4, 1892. Edited by Wm. Perry Watson, A. M., M. D. Recorder Vol. 4. Printed by Baily & Fairchild. 1893.

Transactions of the Medical Society of the State of Pennsylvania; at its forty-second annual session, held at Williamsport, 1893, Vol. xxiv. Published by the Society. Philadelphia: Binder & Kelly.

Eighteenth Annual Report of the Secretary of the State Board of Health of the State of Michigan; for the fiscal year ending June 30, 1890. By Authority. Lansing: Robert Smith & Co., 1892.

Medical Progress.

TUBERCULOUS PERITONITIS.

In a paper in the *Brit. Med. Jour.*, Sept. 30, 1893, Howard March, F. R. C. S., says:

When tuberculous peritonitis is attended with effusion, either into the cavity shut off by adhesions, so that it may be termed encysted, the fluid should be evacuated without delay. Numerous cases show that, when exudation is serous, its removal is likely to be followed by immediate improvement, and the ultimate complete disappearance of all trace of the tuberculous process. When fluid is purulent, the removal of pus may be followed by an uninterrupted recovery.

When tuberculous peritonitis is unattended with effusion, but takes the form of a plastic inflammation matting the intestines together, laparotomy would clearly appear not to be indicated; but, on the other hand, to involve a danger that the intestines may either be wounded when the abdomen is opened, or torn if any attempt is made to separate the coils. Yet several remarkable cases are on record in which, on a mistaken diagnosis, laparotomy has been performed, tuberculous matting found, the wound thereupon closed and the patient has at once improved and has ultimately recovered (Knaggs's second case).

Notwithstanding this experience, however, unless obstruction is present, laparotomy is uncalled for when tuberculous peritonitis is plastic and dry. Especially will this appear to be the right conclusion when the frequency with which patients recover from this condition under appropriate medical treatment alone, is borne in mind.

LAPARO-HYSTEROTOMY.

In an exhaustive article on the indications and technique of this operation, Professor Senn presents the following conclusions:

Conclusions.— 1. Laparo-hysterotomy is justifiable when delivery through the normal passage is impossible without mutilation of the living child.

2. It is absolutely indicated where the conjugata vera is less then two-and-a-half inches, when obstruction is due to fixed pelvic tumors and advanced malignant disease of the cervix.

3. Mutilating operations on a living child for the purpose of effecting delivery are no longer legitimate obstetric procedures, as laparo-hysterotomy and symphysiotomy are life-saving operations for both mother and child.

4. Hysterectomy after laparo-hysterotomy is only justifiable if the uterus itself is the seat of a life-threatening removable disease.

5. Elastic constriction as a hamostatic measure should not be resorted to in laparo-hysterotomy before the delivery of the child.

6. The uterine incision should be enlarged to the requisite extent by tearing for the purpose of diminishing hæmorrhage.

7. The visceral wound should be closed by four rows of sutures applied in such a manner as to absolutely arrest the hæmorrhage, and completely separate the uterine from the peritoneal cavity.

8. Laparo-hysterotomy is only indicated in the operative treatment of single, large myo-fibroma of the uterus in young women when the tumor is located within or near the uterine cavity.

9. In such cases, the uterine incision should be closed in the same manner as in operations on the pregnant uterus, and the bed of the tumor should be packed with iodoform gauze, which is brought through the cervix into the vagina, thus serving the double purpose as a hemostatic tampon and capillary drain.—*American Journal of the Medical Sciences.*

THE USE OF MILK IN BRIGHT'S DISEASE.

Although it is true that many physicians have widely divergent views as to the diet which certain cases of Bright's disease should receive, and while some of them insist very strenuously upon an absolute milk diet, there are others who go even further than this and direct that milk which the patient receives shall always be skimmed. It is not our intention to discuss the relative values of the various dietetic measures which have been instituted, nor indeed of the milk treatment of this condition, but we desire to call attention to an error which, we believe, underlies the administration of skimmed milk in such cases. The main object of all dietetic treatment of Bright's disease is to prevent the ingestion of excessivequantities of nitrogenous material, and theoretically even the nitrogenous principles of milk are harmful. Practically, of course, it is necessary that the patient should receive food containing nitrogen, and milk is therefore used as the best food which we can obtain. If the milk is skimmed, one of the most nourishing principles of it is taken away from the patient, and the part that is taken away contains practically no nitrogen as compared to what remains, and is therefore the part above all others which will do most towards nourishing the patient. We believe, therefore, that whole milk should be given to cases of Bright's disease rather than skimmed milk. It is, however, not to be forgotten that one good reason for removing the cream before giving the milk to such cases is that the fatty material sometimes disagrees with the patient's digestion. This can practically always be avoided by

the administration of pancreatin, or, better still, by diluting the milk until the proportion of fatty material to liquid is so diminished as to make indigestion from this cause an improbability. The milk may either be diluted with plain soda water or Apollinaris, or with vichy, preferably the two first. The carbonic acid gas seems at once to aid digestion by stimulating the stomach and perhaps by aiding in the breaking up of the curd.—*Therap. Gaz.*

TREATMENT OF CANCER OF THE STOMACH.

In a clinical lecture published in *L'Union Medicale* for June 8th, 1893, Peter recommends the following treatment in cases of gastric carcinoma. After dividing these cases into latent, obscure, and evident carcinoma, he recommends that the diet shall consist of milk, or any nutrient liquid which is tolerated, such as kefir; he also believes that rectal injections of peptonized foods are of value. For the pain he believes that the internal administration of opium and the application of irritation externally will often give relief. For the loss of appetite and constipation, which are very frequently associated, he employs tincture of rhubarb, 1 drachm; tincture of nux vomica, 30 drops; and of this mixture gives 10 to 30 drops after each meal.

If pain follows eating, he adds to this prescription some laudanum. In all cases of gastric carcinoma there is a decrease in the quanity of hydrochloric acid. He thinks it is well, for the purpose of aiding digestion and decreasing pain, to prescribe some such mixture as follows:

℞.—Syrup of lemons . . ℥ii;
Hydrochloric acid . gtt. x.
Sig.—A dessertspoonful after meals.

If, for any reason, it is believed that there is a condition of hyperacidity of the stomach, then bicarbonate of sodium may be administered.—*Therap. Gaz.*

STUDIES ON THE THERAPEUTICS OF ACUTE GONORRHŒA.

In a paper on this subject (*Ther. Gaz.*, Oct. 16, 1893) Dr. E. Martin offers the following conclusions:

1. The abortive treatment of gonorrhœa by means of ten-per-cent. nitrate of silver injections applied to the navicular fossa is advisable when the disease is seen in its earliest stage,—that is, when inflammatory phenomena are absent, and when the symptoms consist in the slight whitish discharge and tickling or moderate burning on urination, and when microscopic examination of the discharge shows that it is made up mainly of mucus and epithelium containing little pus. This abortive treatment is successful in an uncertain percentage of cases. When it fails, it does not materially complicate the subsequent course of gonorrhœa.

2. When gonorrhœa is first seen in its florid stage, in addition to ordering rest, light diet, regular evacuation of the bowels, free drinking of plain waters, hot baths on retiring, alkaline diuretics, and the treatment appropriate to ardor urinæ and chordee, balsams should be given in full dose and mild antiseptic irrigations or injections should be practised at once. The most efficient balsams are sandal-wood and copaiba. These should not be pushed to the point of disordering the stomach.

3. Irrigation of the urethra by means of hot antiseptic lotions gives better results than any other treatment. These should be continued either once or twice a day until gonococci disappear from the discharge or from the clap shreds found in the urine. They should then be replaced by astringent injections.

4. When irrigations cannot be employed, even during the florid stage injections are indicated; these should be of bichloride of mercury, 1 to 20,000, or nitrate of silver, 1 to 10,000. These injections should be gradually strengthened as urethral tolerance is established.

5. Injections of nitrate of silver, 1 to 3000, or bichloride of mercury, 1 to 1000, or injection, Brou, or any of the formulæ customarily used in practice in the increasing or florid stage of gonorrhœa, distinctly predispose to the development of hyperacute posterior urethritis, epididymitis, and other complications of gonorrhœa, and may aggravate and prolong urethral inflammation. Strong astringent injections employed in the early period of the subsiding stage are equally dangerous.

6. Treatment by internal medication alone is followed by a small percentage of epididymitis and posterior urethritis, but by slow cure. The most efficient treatment consists in the combination of the balsams with local antiseptic washings.

COSMETICS.

In a paper read before the American Dermatological Association, Dr. R. B. Morison, of Baltimore, said that cosmetics, in a general way, may be divided into two classes, namely, those which are irritating, and those which are soothing. For instance, if we wish to remove freckles or warts, a stronger application must be made than if we simply prescribe for a redness following an acne or an eczema. It is invariably his custom to teach the patient, either through himself or his assistant, how to apply local remedies. Salves, plasters, lotions, and caustics are so often misapplied that experience had taught him to have an application, from which one hoped to get the most good, made by skilled hands to begin with. He finds that nothing suits his patients better for the removal of freckles than the following solution:

℞.—Corrosive sublimate . grs. vij.
Distilled water . . . . ℥vj.
Spirits camphor . . . ℥ss.
Rose water . . . . . ℥v.

Three or four thicknesses of linen, cut to cover the seat of freckles, are moistened with the solution, and placed upon the face at night until they dry, when they are taken off. Whatever remains on the skin is left there till morning, and then washed off. After a few nights' application the face becomes red, and the epidermis begins to peel off in fine scales. Then an ointment is used night and morning, the application being made by gently rubbing it over the face with a clean finger, for five minutes at a time.

In the removal of superfluous hairs the author has given up electrolysis. The results which he had himself, and those which he had seen of others, have not been sufficiently good to warrant its continuance. He finds that the proper application of a good depilatory answers the purpose much better. There are many women who wish to get rid of the white lanugo down on their faces, upon whom it seems that electricity cannot be

used for fear of stimulating the growth of the surrounding hair, and the appearance of permanent scars. If a preparation of yellow sulphate of arsenic and quicklime, of equal parts, made into a paste with hot water, be allowed to dry on the hairy skin, it removes the hair for ten to twenty days, and sometimes permanently. On the other hand, nothing seems to take the place of electrolysis where there are a few strong hairs growing from moles, in the removal of moles themselves, in angioma, or in permanent small red spots.

For the removal of warts the author prescribes the following:

℞.—Hydrarg. bichlor. . . . grs. v.
Ac. salicyl. . . . . 5 j.
Collodion . . . . . ℥ j.

He sometimes increases the bichloride of mercury to thirty grains in the same amount of collodion, if the milder application does not answer. It is applied every day once, the upper crust of the previous application being removed before a fresh one is made. Four such applications generally soften the wart to such a degree that gentle traction removes it painlessly, the further dressing being any simple ointment.

Dr. Morison had obtained excellent results in cases of acne by the use of the galvanic current.

"WORRY" DISEASES.

The *International Journal of Surgery* wisely remarks: There is undoubtedly a large class of diseases which come under a distinct and long recognized head, but there is still another large class to which no name can be given, and to the cause of which even the most careful study of symptoms can lend but little aid. Not infrequently careful comparison of symptoms in the individual with those produced by the drug shows a complete picture, one with the other, alike in all their lights and shades, and yet the drug, if given, may produce nothing more than temporary relief, if even that, simply because the symptoms may have failed to reveal the cause. This cause may exist in the surroundings, in unpleasant associations, in domestic or business worry, and from a hundred causes which drugs have no power to relieve or remove. For one or all of these unnamed diseases, characterized by disturbance, our old friend, Dr. Hempel, of blessed memory, would give *aconite*, and wonder why the drug proved so untrustworthy. Our old school friends, in ninety-nine cases out of a hundred in neurasthenic conditions, would give some of the bromides, with simply palliative effects. If the drug is given simply as a palliative, there can be no objection to it, for very likely the disturbance of the brain is the same, produced by a quarrel with the cook, or as the result of a quarrel between husband and wife, a tiff with one's lover, or worry in business, and the hypnotic action of the drug gives temporary oblivion. It is hardly fair that our learned brothers who criticise so sharply the claims of patent medicines as a universal cure should follow so closely in their footsteps in the use of one specific for every trouble of a nervous origin.

TREATMENT OF PUERPERAL CONVULSIONS BY HYPODERMIC INJECTIONS OF SALT SOLUTION.

The Paris correspondent to the *London Lancet* writes:

The above mode of treatment of puerperal eclampsia is the one now adopted in the lying-in-wards of the Lariboisière Hospital by Dr. Porak, physician-accoucheur of that institution. The salt injections are said to act beneficially by mechanically diluting the toxines in the blood and by favoring their elimination through the kidneys, the secretion of which the injections re-establish or increase. The quantity and quality of urine passed in these cases is, in fact, of great prognostic importance. When the urine is abundant and limpid the toxæmia is mild and the physician may trust to symptomatic treatment by means of chloroform and chloral administered simultaneously (six successful cases of this kind are cited in the recent thesis by Dr. Bernheim, one of Dr. Porak's pupils). In every case, however, where the urine is either completely suppressed or is scanty and dark-colored recourse must be had salt-water hypodermics, either singly or associated with venesection. In Dr. Porak's wards the *modus operandi* is as follows. The solution employed for each injection is one litre of sterilised water to which have been added from seven to seven and a half grammes of chloride of sodium. This is poured into a hand-spray apparatus of which the longer tube end in a hollow needle; or a syphon apparatus may be employed. The solution must be maintained at a temperature of from 37.5° to 38° C. The skin of one of the buttocks having been carefully disinfected, the needle is plunged into the areolar tissue and the salt solution is introduced. The parts near the needle quickly become indurated and the skin becomes pale. Gentle massage is practised to favor absorption. In this way one litre is injected, the operation occupying twenty minutes. Should distension become exaggerated before the injection is completed, the residue of the liquid is introduced into the other buttock. This novel treatment has been tried on eight patients, in all of whom the urine was scanty. Seven were eclamptic and the eighth suffered from the dyspnœic form of uræmia. In each instance one or two salt injections were the means of re establishing the urinary flow and of suppressing more or less promptly the convulsions and the dyspnœa in the uræmic woman. Six patients recovered. Of the two women who died one was admitted in a moribund state, and the other, in whom the attacks had ceased and consciousness had returned, died at home, where her husband had obstinately insisted on removing her.

NERVOUS LESIONS IN DIPHTHERIA.

In the Russian *Vratch* Dr. Stscherbak gives an account of some experimental researches which have been carried out in Professor Strauss's laboratory, and a short summary of his paper is given by Dr. Rosenbach in a recent number of the *Neurologisches Centralblatt.* The animals experimented upon were rabbits and Guinea pigs, and they were inoculated with diptheritic bouillon cultures or the filtrate of these. Many alterations were found in the nervous system of such animals after the inoculation, such as hæmorrhages in the spinal meninges and in the grey matter of the cord, acute inflammation of the latter, degenerative changes in the spinal roots, neuritis of peripheral nerves, and changes in the muscles, both parenchymatous and in-

terstitial. Similar changes have been described by various observers as occurring in patientswho have died fromdiphtheria, and Dr. Stscherbak's researches would seem to indicate that they are a direct result of the disease. Besides showing the correspondence between the conditions observed in man and those produced by inoculation in animals, however, these experiments indicate also the cause of diphtheritic paralysis as essentially consisting in inflammation of the peripheral nerves, the other changes in the nervous system being of subordinate importance and significance. In all the cases in which paralysis followed the inoculation in these animals neuritic changes in the peripheral nerves were found. The intensity and extent of the neuritis corresponded generally with the degree and locality of the paralysis. The fibres of the peripheral nerves going to muscles were mostly affected. The neuritic processes were found to be independent of changes in the spinal cord and the latter were present in cases in which there was no paralysis.—*Lancet.*

THE USE OF PURGATIVES IN SURGERY.

It was an old German physician who said, "who purges well cures well," and although the use of purgatives is no longer resorted to in the same arbitrary fashion and with the some energy as in the times when, together with the lancet the emetics and mercurials, they were the chief weapons in the physician's armamentarium, every one will concede that there is much truth in the old axiom. Witness the marvellous effects of the time-honored rhubarb and soda mixture in dispensary practice. In the practice of surgery the purgatives are rarely referred to, and yet their judicious use is frequently capable of greatly improving the patient's condition and adding to his chances of recovery. In the treatment of peritonitis the saline cathartics have to a great extent supplanted opium, which since the days of Alonzo Clark had been considered as a *sine qua non.* Recently Dr. Nicaise, in a paper read before the French Association for the Advancement of Science, pointed to the importance of intestinal evacuants in the treatment of persons subjected to operations or of the wounded. He claimed that after an operation the metabolism is altered by the anæsthesia and by the shock inflicted by the operative procedure, in consequence of which the indication presents itself to relieve the organism by facilitating the excretion of the products of metamorphosis. During the first two days he advises that the patient should receive only beverages, and later easily digestible, semi-fluid food. The chief indication, however, is to secure the proper function of the intestinal tract by the administration of purgatives and intestinal disinfectants. In some of his cases the drastics proved most serviceable, and in cases where purulent material was present in the intestinal canal and the stools were illsmelling the salines were efficient, leading to a profuse hypersecretion of the intestinal mucous membrane, and thus disinfecting the canal. In the later stages of the healing process, purgatives also should be given especially when the stools are very fetid. As an illustration of the beneficial effects of this procedure, Nicaise reported the case of a man suffering from gangrene of one leg following laceration of the femoral artery. Am-

putation was refused by the patient and measures were therefore taken to encourage separation of the gangrenous extremity. Everything was going well, a line of demarkation had formed and the limb became mummified, when septicæmia developed. The stools were thin and offensive. On the third day of the disease purgatives were given, which were repeated every three days whenever the stools became fetid. After sixteen days' treatment the gangrenous extremity was detached, and complete recovery ensued, which the author ascribes in part to the influence of purgatives and a careful diet. In discussing this paper, Dr. La Gendre spoke against the indiscriminate use of intestinal evacuants, and emphasized the point that in every case the disturbance of the renal function produced by too violent action of the bowels should be considered. He also regarded the condition of the intestinal canal before operation as of importance in the selection of evacuant remedies. He had found that many dyspeptics exhibit an intolerance to certain cathartics. Thus, in cases of deficient secretion of pepsine, Glauber's salt has an injurious action by diminishing or even suspending peptic digestion. In his opinion, it is of great importance to secure antisepsis of the intestinal canal, which aside from the use of drugs may be obtained by enemata of water having the temperature of the body and allowed to flow slowly into the gut under a low pressure. Among the stronger purgatives he preferred calomel which in five grain doses four times daily exerts an intense antiseptic effect, perhaps of greater importance than its cholagogue action, and also serves as a diuretic.

Whatever be our views regarding the efficacy of intestinal antisepsis, it cannot be denied that mild cathartics subserve a useful purpose in certain surgical cases, before or after operation. Aside from their function in cleansing the intestinal canal of fecal matter and products of decomposition, they exert a powerful systemic effect by elimination of the poisons generated in tissue metabolism, and by relieving congestion and consequently preventing inflammation. It goes without saying that great caution should be exercised in their employment.—*Inter. Jour. Surg.*

FRACTURE OR LACERATION OF WINDPIPE IN CHILDREN.

In an interesting address on surgery of the air-passages and thorax in children (*Lancet*, Sept. 9), Dr. Pitts, of the Great Ormond St. Hospital, of London, says:

Cases of fracture or laceration of the larynx or trachea are very unusual in children. In the *Lancet* of Dec. 10th, 1887, Mr. Garrard, of Sheffield, reports the case of a girl aged eleven who fell on a sharp-edged slate which was hanging round her neck. She was admitted an hour afterwards to Rotherham Hospital. The neck was bruised and emphysema had already extended from the neck to every part of the body, including the fingers and toes. She died a few minutes after admission. No post-mortem examination was obtained, but a distinct depression could be felt below the cricoid cartilage. At the Pathological Society, on Dec. 1st, 1874, Mr. Godlee showed a rupture of the trachea from a boy aged seven which had been caused by the wheel of a cart. The rupture was associated with fracture of the third, fourth and fifth ribs. The trachea was split at

the front and back immediately above the bifurcation. The child died shortly after admission; no emphysema was noted or found post-mortem. In the *Edinburgh Medical Journal* of October, 1823, Liston records the case of a fine healthy boy eight years of age who fell and struck his larynx against a stone. He was taken up in a collapsed state and with lividity of the face. The temporal artery was opened and leeches were applied to the neck. When Liston saw the case three hours later the breathing was very difficult, especially inspiration. Tracheotomy was performed with marked relief, coagulated blood and mucous being evacuated. The tube was kept in for eight days and the child recovered. In the *American Journal of the Medical Sciences*, 1858, Atlee records the case of a child four years of age who fell and struck his neck against a scraper. Difficulty of breathing at once ensued, but when seen by Atlee the child was breathing quietly in his mother's arms. He then suddenly began to struggle, and threw his head back; his neck became at once enormously swollen and almost directly the child was dead, the emphysema extending to the finger-tips. A post-mortem examination was refused.

HOW TO INCISE POST-PHARYNGEAL ABSCESS IN CHILDREN.

In the *Lancet*, also, Dr. Pitts speaks thus of neck abscesses:

Compression of the trachea in the neck may be caused in children by abscess, by enlarged glans, by goitre or by a foreign body impacted in the œsophagus. Abscess in the neck, producing compression of the trachea or inflammatory œdema of the glottis, is most likely to be post-pharyngeal in position. The advantage of opening a post-pharyngeal abscess by incision in the neck and not within the mouth is now fully recognized, particularly if the abscess is dependent on vertebral disease and the discharge is likely to be continuous. If the difficulty of breathing is urgent and the dissection from the neck likely to be too prolonged, tracheotomy will be advisable as a first step. Intubation would seem to be contraindicated by the possible alterations in the relations of the layrnx and trachea. If, however, the abscess is small and there seems to be a difficulty in getting at it from the side of the neck, a vertical incision may be made from the mouth; but care should be taken to bend the child's head quickly forward so that the pus may run out of the mouth. If radical treatment is postponed, pressure symptoms may become urgent, or rapid œdema of the glottis may arise, or the abscess may burst spontaneously and death take place by suffocation, particularly if the abscess should burst whilst the child is asleep. In children under a year old these abscesses do not often depend on cervical caries, but arise from causes which produce similar abscesses elsewhere, such as inflammation around the lymphatic glands in front of the vertebræ; or they are secondary to tonsillitis, disease of the ear, or after catarrhal conditions of the posterior nares and fauces. In 204 cases, which were recorded by Bokai as occurring in the Children's Hospital at Pesth, only seven were secondary to caries of the vertebra.

SPINAL CORD IN PERNICIOUS ANEMIA.

A recent German investigator states that two distinct groups of changes were found. The first consisted of capillary hæmorrhages, similar to those occurring simul-

taneously in the retinæ, with their consequences — viz., patches of miliary sclerosis. These were particularly noticed in hardened preparations. The second group of changes was only noticed after hardening, the fresh cords presenting no other appearance than was to be expected in cases of extreme anæmia. In the hardened specimens this change consisted in a strong bright coloration of the posterior columns of the cord in its entire length, not unlike the ordinary posterior sclerosis of tubes, but without any shrinking. There was also visible at the peripheral parts of the anterior and lateral columns a somewhat diffuse bright-yellow color. The cord substance was very brittle, the effect of a process of softening affecting the grey as well as the white matter, but especially the posterior columns. Exactly similar changes were found in a case of leucæmia and in one of tumor of the inferior vermis of the cerebellum—i. e., in cases of long-continued illness which had much reduced the patients. The microscopical appearances were very similar to those found in true spinal cord affections, but the changes evidently depended on a condition of œdema of the cord. The writer considers it not impossible that the dropsical changes originating in the course of severe illnesses may really be the starting point of a true degenerative disease of the spinal cord.—*Ex.*

Recommendations of Therapeutic Agents.

SALOPHEN IN ACUTE RHEUMATISM.

In the *Medical Record*, July 29, 1893, Dr. D. B. Hardenberg, of the New York Post-Graduate Medical School, reports a series of cases of acute rheumatism treated in the wards of Drs. Dana and Brannan, in Bellevue Hospital, by means of salophen.

Case 1. Laborer, æt. 46; mild attack; salophen, gr. xv t.i.d.; cured in 12 days. Case 2. Colored man, 35; temperature 10.2°, local symptoms well marked; salophen 6 doses of xv gr. in 24 hours; temperature went to 105° on same night, then to normal, where it remained. Case 3. Laborer, æt. 30, pain very pronounced; temperature 103°4; salophen, 7 doses of xv gr. in 24 hours; menthol locally; temperature went to normal on third day. Case 4. Laborer, æt. 34 (the treatment was not completed on account of transfer). Case 5. Laborer, æt. 22; temperature 102°; 7 doses of 15 gr. salophen in 24 hours; complete convalescence in 7 days. Case 6. Laborer, æt. 16; temperature 103°; salophen, gr. 15, every 2 hours for 36 hours; then every four hours; menthol 5 per cent. locally; discharged cured in 5 days. Case 7. Longshoreman, æt. 55; temperature 101.4°; salophen, 7 doses of 15 gr. in 24 hours; discharged cured in 10 days. Case 8. Longshoreman; temperature 103°2; salophen, 6 doses of 15gr. in the 24 hours, menthol and lead and opium locally; discharged cured in 12 days. Case 9. Tailor, æt. 33; temperature, 102°6; salophen, 8 doses of 15 grains in 24 hours; temperature normal on 3rd day; discharged in 8 days. Case 10. Driver, æt. 31; temperature not high; pain intense; salophen, gr. xv, 9 doses in 24 hours. Temperature normal on 3rd day.

Conclusions: Dosage, gr. xv, 6 to 7 times in 24 hours, may be considered adequate. Tolerance: There was no gastric, aural or other irritant or toxic property manifested. Even when ele-

vated doses were given (as in Case 6, for example,—270 grs. in 36 hours) no ill effects were observed. Therapeutic effect: The average febrile period being 6.1 9 days, and period of cure less than 10 days, attest great curative value. Abatement of other symptoms equally rapid; no cardiac complications; a 5 per cent. solution of menthol in gauze, covered with oiled silk, is a valuable adjuvant.

Medical Items.

No Change.—Briggs—"You say your doctor sends you a bill twice a year?"

Griggs—"Yes."

"What does he do that for?"

"It's the same bill."—*Judge.*

The position of health officer of Detroit, Mich., pays an annual salary of $5,000. The same position in Baltimore pays $3,000. Detroit has not quite half the population of Baltimore. Comments are unnecessary.

Dr. Robert Battey, of Rome, Ga., has presented his medical library to the State of Georgia upon the condition that it be placed in a separate alcove in the State Library at the State Capitol as a nucleus of a State Medical Library.

The Mütter Lectures this year will be given by De Forest Willard, M. D., at the Hall of the College of Physicians in Philadelphia on Tuesday evenings from October 17th to December 19th. The subject is "The Surgical Pathology and Surgery of the Spinal Cord, the Vertebræ and Peripheral Nerves."

At the 283rd regular meeting of the Maryland Clinical Soctety, held October 20th, the following officers were elected to serve for the ensuing year: President, Dr. J. Edwin Michael; Vice-President, Dr. Herbert Harlan; Recording Secretary, Dr. H. O. Reik; Corresponding Secretary, Dr. William T. Watson; Treasurer, Dr. W. J. Todd; Executive Committee: Drs. J. M. Hundley, Wm. F. Lockwood and J. M Craighill; New Member of Finance Committee, Dr. W. Green.

The commodious new building of the New York Pasteur Institute, which is situated in Central Park, at the corner of 97th Street, was opened with appropriate ceremonies on October 9th. Addresses were delivered by Dr. Paul Gibier, the Director of the Institute, by Prof. R. Ogden Doremas, and by Vicomte d'Alzac, Consul General of France; after which a collation was served.

The American Public Health Association elected the following officers for the ensuing year; Dr. Emanuel P. La Chappelle, President, Montreal; Dr. M. Carmona y Valle, of Mexico, First Vice-President; Dr. J. N. McCormack, of Bowling Green, Ky., Second Vice-President; Dr. Henry D. Holton, Brattleboro, Vt., Treasurer; Dr. Irving A. Watson, Concord, N. H., Secretary. Place of meeting, Montreal, October, 1894.

Dr. Wm. H. Galt, one of Louisville's most prominent physicians, died on Oct. 14th, at the age of 67. Dr. Galt was at one time one of the editors of the *Louisville Medical News* and held the chair of Theory and Practice of Medicine in the Louisville Medical College. He was also Health Officer of Louisville for a number of years. He bore the reputation of being a brilliant and scholarly physician, a

clear teacher, a sincere friend, a christain and a gentleman. What more can be said of a man?

The Very Meanest Man.—The meanest man has certainly been located. He lives in Carroll County, Ga., and the *Carrollton Times* says of him:

"For gall and cheek one of the *Times* subscribers takes the cake. Instead of coming into the office he passed by and went to the post-office and mailed a letter notifying us that he did not wish the paper continued. He refused to put a stamp on the letter, and we had to pay the postage."—*Ex.*

Dr. Charles H. Ohr, one of the most venerable and respected members of the medical profession in Western Maryland, celebrated on Oct. 19th the eighty-third anniversary of his birth at his home in Cumberland. Dr. Ohr was born in Washington Co., Md., but removed to Cumberland in 1847, where he has since resided, and where he is still in active practice. Dr. Ohr was president of the Medical and Chirurgical Faculty of Md. in 1873-74. He has been prominent in every movement looking to the advancement of his profession in this State. The JOURNAL wishes Dr. Ohr many years of good health and usefulness.

There are few of the English physicians better known and more highly esteemed in the country than Sir Andrew Clark. It is, therefore, with sincere regret that we have learned, by cablegram, of the extreme illness of this distinguished member of our profession. In view of many years of earnest labor in his profession, and of his age, we are very apprehensive of serious results upon his future professional usefulness even should he escape with his life. Wherever the literature of our profession is extensively read the value of Sir Andrew Clark's services to clinical and scientific medicine are recognized. He has brought honor and dignity to the profession of Great Britain, where he stands with few equals and no superior as a medical practitioner.

The Faculty, associates and instructors connected with the Hopkins Medical School and Hospital did a graceful and appropriate act in celebrating the 100th annniversary of the death of John Hunter. Addresses appropriate to the occasion were made by Prof. Osler, Prof. Welch, Dr. Billings and others. John Hunter was not only the greatest surgeon and pathologist of his day, but there are few men of modern times who measure up to his standard of genius and attainments. If all that he did for his profession was obliterated, the knowledge we possess to-day would be far behind our present standard. Mr. Timothy Holmes, in speaking of the Life and Works of Hunter, says:

"The first thing that strikes the student of Hunter's life is its immense laboriousness—at least in his later years. His day began with sunrise in summer, and long before dawn at other seasons, after about four hours in bed; and then, from 4 to 5 in the morning, he used to dissect till 8 o'clock breakfast. Then he saw his patients or pursued his researches till he had to go his rounds to the hospital or his office of surgeon-general, or his patients in the city; and after his frugal dinner at 4 o'clock and an hour's sleep, he resumed his labors till midnight brought the day to an end."

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Original Articles.

A SHORT TREATISE ON "SKIASCOPY."

BY EDWARD J. BERNSTEIN, M. D.,
OF BALTIMORE.

Among the many scientific achievements which we owe to the genius of Helmholtz, none surpass in value the discovery of the ophthalmoscope. This illustrious savant grasped at once its many applications, one of the most felicitous of which was that of objective optometry, which for a long time remained neglected, but is now daily becoming more and more popularwith the profession. Although brought to our notice in 1851, it was not until 1874 that any one method had been brought to a sufficient degree of exactitude.

The method by direct examination, as already stated, was introduced by Helmholtz, recommended afterwards by Jaeger in 1856 ("Der Augenspiegel, als Optometer") and was finally systematized to such a degree by Manthner in 1866 ("Lehrbuch der Optholmoskopie)," that it practically exhausted the subject and reduced further investigation to perfection in instruments alone. In this latter, I take it the perfection is found in the Morton ophthalmoscope, a modification of Mr. John Couper's. But to Cuignet, of Lille, who, in 1874, first called attention to the direction of the shadows produced during ophthalmoscopic illumination, although he made no practical use of this knowledge, we owe a great deal.

Mengin, his pupil, brought this to Paris and to the notice of Parent, who looked further into the matter; and com-

prehending its true significance, gave it a physical explanation and deduced a clinical application. Parent then made of it a regular, simple and precise method for the rapid determination of spherical and astigmatic refraction, which far surpasses the old method of *direct* examination.

He used a concave mirror—and interposed between this mirror and the eye examined the glass which corrected the ametropia. Thus skiascopy was created. Modification of detail and such perfections as have been added to it, such as substitution of the plain mirror for the concave and the determination of myopia, without glass, by the *punctum remotum*, have been determined on as practical tests, and increased knowledge. Skiascopy has become, in ten years, at once the most sensible, the most precise and the simplest of all objective means for determining ocular refraction. The names variously adopted for this method from keratoscopy, by Cuignet (in reference to the cornea), have successively changed to pupilloscopy, fantoscopy, photoscopy, retinoscopy) and now, properly, skiascopy, from *skia*, Greek for shadow, and *optikos*. The term keratoscopy belongs to the method of Javal and his followers, who study the topography of the cornea, also of great importance.

The *application of skiascopy*.—The indispensable condition necessary for the proper application of its principles in the determination of refraction and to obtain the maximum of precision from it are the following:

1. To work in a darkened room.

2. To have the pupils thoroughly dilated *or at least quiet*.

3. To so arrange the source of light—a student lamp or an Argand burner, supplied with a darkened screen behind it—that the face of the patient shall be in the deepest shadow. This is best done by having the light behind the patient and directly over the vertex of the skull.

4. Use a plain and circular mirror of from 30 to 40 m. m. in diameter, with a central perforation (which, however, should not be entirely through the mirror, but only taking off the silvering, leaving the glass clean) of at least 4 m. m. in diameter.

If the central perforation is through the entire thickness of the mirror, it will produce confusion-shadows.

5. The ametropic observer can practise skiascopy without his correcting glass, but he must wear it if he wishes to arrive at the greatest precision.

6. The patient, if not under a mydriatic, directs his gaze directly in front of him at the darkened wall, 5 metres off, and the observer places himself directly in the line of vision in order to watch the play of the shadows in the macular region; or, if under atropin or homatropin, the patient gazes directly into the mirror held by the observer. You thus get the minimal angle with the patient's line of vision.

7. The luminous cone is easily directed to the patient's forehead, thanks to the darkness of the background on which it is projected. It is from this place easily directed to the eye, which we now see illuminated in the pupillary region. Now, by very slowly rotating the mirror on its axis up, then down, you will see the light in pupil give way to darkness and you are thus enabled to tell the direction the shadow (or darkness) takes; its intensity and rapidity of movement in the

vertical meridian; now executing the same movement with the mirror from side to side (only on the mirror's axis), you can at once see whether the movements are in the same or opposite direction. If the latter, you know at once that you are dealing with a case of mixed astigmatism.

8. It is understood that the distance between observer and observed should be at least 1.25 metres.

Myopia.—If the observed eye has a myopia of over 1 degree, the image and its accompanying shadow seen is an inverted one, and moves in the *opposite* direction to mirror's movements. There are two ways of determining the amount of myopia.

1st. To rapidly approach the patient, constantly rotating the mirror, until the shadow ceases to move in the contrary direction (ceasing to be an inverted image), then measuring this distance from the patient's eye, which will give the focal distance of the correcting concave glass for this meridian or axis; doing the same thing for the meridian at right angles to this (Chibret's method).

2nd. Seated at a distance of 1.25 m. from the patient, place the lowest concave glass immediately before the patient's eye, which will turn the direction of the shadow's movements, *i. e.*, give the most feeble direct image, making it move in the same direction.

The employment of the first method avoids the tediousness of the second, and increases, by consequence, its precision where no mydriatic is used.

Hypermetropia.—In this only the one method is used, which consists, as in myopia, in the searching for such a glass as will just turn the shadow's movements, which are in the same direction as the mirror's movements (being a direct image), into an inverted image, and whose movements will be against your movements. The glass which just does this is the measure of the hypermetropia.

Astigmatism.—Here at once, if the flame of your lamp be of the same dimensions in height as well as breadth, you will see instead of the square image of the light on the patient's retina, a rectangular image, and more or less so as the difference of refraction of the two principal meridia is greater or less. (Bowman called attention to this in 1859 and Donders in 1863 in his treatise on "Errors of Refraction and Accommodation." (See note, page 460, English edition.)

If, however, this rectangle is not sufficiently distinct, the astigmatism is discovered during the comparative examination of the two principal meridia. In mixed astigmatism it is shown by the difference in direction of the movements of the principal meridia. In simple astigmatism of very low degree—under 1 dioptre—it is also seen by the slight difference in the intensity of the shadows of the two principal meridia. The delicacy of this method is such that an astigmatism of 0,25 D. is readily detected and in certain cases one can approximate to 0,1 D.

Compound astigmatisms are corrected by correcting each meridian in turn, begining with the least ametropic, the difference between the two representing the amount of astigmation. The least ametropic meridian minus 0. 75 D. represents the amount of spherical correction to be given.

In mixed astigmatism, H. in one meridian, and M. in the other, one finds

first the glass correcting the H. meridian then that correcting the M. meridian, the difference between the two being the amount of astigmatism.

One thing to be noted in the practice of skiacopy is that the shadow is so much the deeper and its movements across the fundus of the eye so much the slower according as the ametropia is more pronounced.

I have gone more deeply into the physics of this subject in an article read a year ago and will be pleased to furnish such to those who wish it. To these I would say that a very complete treatise on the subject can also be found in the article of Parent in the Helmholtzsche Zeitschrift, and in Berry's book on Diseases of the Eye, edition of 1893.

As a mydriatic I use a 1 per cent. solution of the hydrobromate of homatropin dissolved in ol. ricini; of this one drop placed on the lower lid will produce full mydriasis in 45 minutes, when one can proceed.

Where no mydriatic is used, one should be careful to rotate the mirror as little as possible and to work quickly, otherwise you will easily produce spasm of the pupil and accommodation.

In speaking of this method Schweigger says: "I was astonished to see how often I discovered cases of mixed astigmatism since I employed this method.

Fuchs says: "The method is one of great simplicity; it is the easiest of all methods and has the advantage that one may totally disregard his own ametropia and at the same time obtain the most accurate results. Parent says: "This system and the name given it by Cuignet is the most exact of all the processes of objective optometry and thanks to the discovery of Helmholtz, the oculist to-day can determine objectively the amount of his patient's ametropia in a manner at once precise and rapid."

In conclusion I wish to call attention to:

1. The readiness with which one discovers small maculæ corneæ, which often otherwise escape attention, and how much nearer you will be able to approximate the irregular astigmatism of such eyes and give comfortable glasses.

2. The advantage of being full master of the patient's static refraction, to the importance of which I have already called attention, in an article on "strabismus" in *N. Y. Med. Journal*, April 22, 1893.

After a continuous trial of skiascopy for more than two years in hospital and private practice I can only add my small quota of commendation for all that has been said in its favor.

800 Madison Avenue.

SOME PRACTICAL POST-MORTEM POINTS.*

BY HENRY W. CATTELL, A. M., M. D.,

Demonstrator of Morbid Anatomy in the University of Pennsylvania.

1. Get all the anatomical knowledge you can out of every autopsy you make. It is, therefore, usually advisable, especially in the case of females, to perform a preliminary laparotomy. Many surgical operations can be practised upon the body without disfigurement, such as Alexander's operation, oöphorectomy, removal of the ear ossicles, and vermiform appendix, stretching of the sciatic nerve, symphyseotomy, etc.

2. Do not forget to dictate the post-mortem notes while the autopsy is in progress.

3. Respect the feelings of the friends in every possible manner, and always re-

*Read before the Philadelphia County Medical Society, October 25, 1893.

turn everything in a private house to its proper place. Be sure to leave no blood marks behind.

4. Be sure you have a legal right to make the post-mortem before you begin. The nearest relative, or the one who is going to pay the expenses of the funeral, should give the consent in writing.

5. Do not take away more tissue from a post-mortem than you are able to thoroughly work up.

6. Try to encourage a demand among the laity for the performance of autopsies.

7. In making an autopsy have a regular method for its performance, which is only to be modified by exceptionable circumstances. Finish the examination of each organ in as thorough a manner as possible before the examination of another organ is commenced.

8. Label all your specimens at once with name of person from whom the specimen is removed, character of the specimen and relations in the body, date, and preservative fluid employed.

9. If you are so unfortunate as to cut yourself, wash the wound with running water for four or five minutes, and then dress antiseptically. Do not, out of bravado, go on with the post-mortem, if there be any one else present who can complete it.

10. If you are not making the autopsy yourself, do not be too forward in making suggestions to the one who is making it; but always be ready to do anything that you are asked to do in connection with the autopsy.

11. Let your medical friends enjoy the autopsy and specimens with you.

12. Get all the posts you can; never refuse to make an autopsy for another, when you possibly can.

13. Tact will get you many autopsies; curiosity of relatives and friends can often be worked upon to get permission for an autopsy.

14. As the object of the autopsy is usually to find out the cause of death, either for legal or scientific purposes, the post-mortem should, therefore, be conducted in as thorough and accurate a manner as possible.

15. In legal cases be sure to protect yourself in every possible way. The jars (which should never have been used) containing the specimens should be sealed in the presence of a witness. In important cases in Philadelphia, the coroner has both of his physicians present at the autopsy, so that the testitimony is stronger; and in case of absence of one of the physicians the other can go on the witness stand and the case not be postponed.

16. If you value your peace of mind do not put yourself forward as an expert witness in medico-legal matters. Knowledge which you already have should be freely given to the court in criminal cases, but the court cannot compel you to obtain expert knowledge without your consent.

17. In Germany the legal evidence of a post-mortem held by gaslight has been judged by the court, under certain peculiar circumstances, to be void.

18. If two persons are lifting the body the lightest weight is at the feet.

19. Chloroform, when placed on a towel and the head enveloped in the towel, will quickly dispose of pediculi capitis.

20. Many signs of inflammation, especially of the mucous membrane, disappear after death. Remember that red flannel often colors the skin red.

21. Make the undertaker your friend. Do not recommend an undertaker who disapproves of post-mortems.

22. It is a good knife that will keep its edge in more than one post-mortem.

23. Do not jump at conclusions too quickly. Tentative diagnoses alone should be made until the post-mortem is complete.

24. Always weigh the important organs, and have some method by which you can tell the right from the left organ in case of the double ones. One nick in the left-side organs and two in the right will readily distinguish them.

25. Wash your hands frequently during the performance of an autopsy so as not to allow the blood to dry on the skin.

26. In opening a cystic kidney be careful that the liquid does not injure the eyes or soil the linen, as when the kidney is opened the liquid in the cyst is under pressure and may squirt several feet.

27. A duct can often be easily followed by making a nick in it, and then introducing a piece of broomstick or a groove director in the direction you desire to dissect. This is especially useful in the ureters and the ductus choledochus communis.

28. In writing the account of an autopsy describe what you see; do not use names of diseased conditions. These should be put in under the head of pathological diagnoses.

29. Urine, or aromatic spirits of ammonia, will best take off the odor from your hands. This odor is usually gotten from opening the intestines.

30. Ammonia (also the aromatic spirits) will remove iodine stains; a weak solution of the hypobromate solution will remove carbo-fuchsin and other aniline stains from the hands.

31. Any organ which you desire to save should be placed in a safe place so that it will not be returned to the body and sewed up.

32. The dissecting room is a poor place to study pathology, on account of the chloride of zinc forming with albumen an insoluble albuminate of zinc.

33. Nervous tissue for microscopic study should not be placed in zinc chloride or in alcohol.

34. Remember that a post-mortem, with the exception of the brain and cord, can be made with a penknife.

35. Remember that the thoracic and abdominal organs can be removed by the rectum or the vagina.

36. Before removing the calvarium have a basin so placed that it will receive the blood and cerebro-spinal fluid.

37. Drawings, photographs, casts, cultures of micro-organisms, and microscopic slides are valuable additions to a well-written account of an autopsy.

38. A lesion in one part of the body will often suggest a careful search for a lesion in another part of the body.

39. Do not mistake the normal for the abnormal.

40. Squeezing the gall-bladder after the duodenum has been laid open will often cause bile to pass out, and the papilla, the ending of the common bile-duct, can thus be demonstrated.

41. Remember that frozen sections of fresh tissue can be cut and mounted in a half hour to an hour.

42. Three hours is none too long in which to make a complete autopsy.

43. Be careful that the first rib does not scratch the hands when removing

the tissues in that region. Therefore cover over the cut ends of the clavicle and ribs with the skin flaps.

44. Blood makes a good glue for affixing labels, and the blood of a person dying from hydrocyanic poisoning makes a most excellent red ink which will keep for years without the addition of any preservative fluid.

45. Remember that after the brain has been removed the fundus of the eyes can be removed by a circular incision posteriorly, without disfigurement. The inside should then be stuffed with dark-colored wool or cloth.

46. In private cases you will be frequently judged of your skill as a pathologist by the neatness with which you sew up the body.

47. If you discover suspicious lesions always stop the post-mortem and report the case at once to the coroner.

48. Remember that in warm weather the intestines are especially liable to undergo rapid decomposition when exposed to the air.

49. Remember that a railway train or cart may pass over the body and there be no abrasion in the skin more than a brush burn.

50. Remember that the color of organs is frequently changed when exposed to the air by the oxidation of the hæmaglobin. Also that the sulphide of iron frequently discolors organs after death, due to the sulphuretted hydrogen decomposition precipitating the Fe of the hæmaglobin.

51. The clavicle can be grasped and moved and the claviculosternal articulation thus readily discovered.

52. In removing the cord the following method may be used without disfigurement to the skin of the back part of the neck. Make a circular incision from the middle of the trapezius muscle of the one side to the middle of the same muscle of the other side, using as the centre of the circle the external occipital protuberance. This will take you in the median line to about the second dorsal vertebra; then dissect away the skin with the muscles attached, and elevate this flap with a tenaculum and draw the shoulders backward. A sufficient amount of space will be given to then remove the cord in the usual manner.

53. If the rectus muscle on each side be cut near its origin, in the direction of Poupart's ligament, the abdominal cavity will be much more thoroughly exposed to view than in the ordinary manner. First, however, examine with the finger for hernia.

54. And lastly, be honest. Everyone diagnoses lesions during life which are not found at the post-mortem. Even after a most careful post-mortem it is often impossible to tell from what the patient died.

Society Reports.

BALTIMORE MEDICAL ASSOCIATION.

MEETING HELD MAY 22, 1893.

Dr. John T. King, 1st Vice-President, in the chair.

Dr. E. Dorsey Ellis reported a case of ACUTE BRIGHT'S DISEASE in a woman four months pregnant, 32 years old. Had been in good health up to present time. She had puffiness around the eyes, swelling of ankles, vertigo, vomit-

ing, and slight headache. When he saw her, the pulse-beats were 150 and feeble, and there were violent headache, cyanosis, dyspnœa, rapid respirations and the lungs were filled with serum. She was expectorating a fluid resembling milk. The urine contained 50 per cent. of albumen. He administered the compound spirits of ether, which seemed to augment the cephalalgia. He also gave pilocarpine, gr. one-twelfth. That day the patient passed less than the usual quantity of urine. Pilocarpine was given again the next day. About a week afterwards she was feeling well. The treatment consisted of milk diet, infusion of digitalis and bitartrate of potassium. She is apparently well at the time of this report.

Dr. Ellis is now attending a laboring man 45 years old, who has been a hard drinker until recently. The features of the case were dyspnœa, no rales, extremities cold, cyanosis, urine of dark amber color, with 45 per cent. of albumen, ankles slightly œdematous, and eyes somewhat puffed. He had formerly passed a great deal of urine. Œdema of ankles is persistent. Urine now contains a little less albumen. Treatment: pilocarpine, bitartrate of potassium, and digitalis. The patient had improved slightly.

Dr. S. A. Keene said that never until recently had he had an experience like Dr. Ellis' case. He is now attending a primipara whose feet were slightly swollen. She afterwards suffered with considerable cephalalgia. She was also greatly anasarcous. He used diuretics and hydragogue carthartics, and punctured the labia to give relief. The next day she had five convulsions. After the inhalation of chloroform and the hypodermatic injection of morphia (gr. $\frac{1}{2}$) the convulsions ceased. Sight was impaired after the convulsions and the mind wandered. Several days afterwards convulsions returned. They were treated in the same way. She was unconscious all night, but felt well next morning. To-day she is suffering with cephalalgia and everything seems dark. Morphia given. She is now passing more water than usual but is yet very œdematous. She is now in 9th month. Many of these cases look like nephritic trouble but yet the urine contains little or no albumen. The symptoms, however, indicate uræmia. It is rare that we have eclampsia so long before confinement. What causes this train of symptoms and what is the treatment? He does not use pilocarpine very much, as he is afraid of the bronchorrhœa that it sometimes produces. He uses diuretics and hydragogue cathartics. In this case the œdema comes and goes.

Dr. C. H. Jones thinks that the origin in Dr. Keene's case may have been cardiac; the exciting cause, the gravid uterus. Some hysteria was also likely. Dr. King asked how he accounted for the convulsions. Dr. Jones replied that there was probably some uræmia. He would not have used morphia as heroically. Veratrum viride would have been appropriate.

Dr. E. G. Waters said that he was very much impressed with a remark in Dr. Tyson's work in regard to the use of nitric acid in urinalysis. Nitric acid used before the application of heat does not always coagulate albumen. Therefore use it after heat. Dr. Waters suggests the use of picric acid in urinalysis. This is almost unfailng. Tyson says

that a small quantity of albumen is often more significant than a large amount. Dr. Waters referred to a paper read before this Association several years ago by Dr. J. Harvey Hill, in which premature labor was strongly recommended in such cases, convulsions occurring several months before parturition.

Dr. James J. Wiltshire said that it was very interesting to study Dr. Ellis' case, in which there was considerable degeneration of the epithelial lining of the uriniferous tubes. Dr. Ellis thought that it was contracted kidney, but Dr. Wiltshire said that it might have been large white kidney owing to great vascular disturbance. Digitalis is not always advisable. In Dr. Ellis' case, however, it accomplished good results. In cases like Dr. Keene's, morphia is condemned by authors, but in this instance it did good. Dr. Wiltshire advises rest of the kidneys, and the use of diuretics and hydragogues.

Dr. Ellis replied, giving his reasons for supposing that the man (his second case) had contracted kidney; viz., his habits (drink), laboring life, polyuria, heart failing. He used digitalis because the case was urgent, and the heart needed stimulating. In regard to Dr. Keene's objection to pilocarpine (bronchorrhœa), he thinks that it is rare. When giving this drug, keep the skin very warm.

Dr. Wiltshire said in explanation that it is desirable to get the loops of Henle cleared of *debris*. This Dr. Ellis got from the cream of tartar without getting the full physiological effect of digitalis.

Dr. John D. Blake does not believe that digitalis is a diuretic. It contracts the arterioles. Vaso-motor dilatation exists pressing upon the secretory cells of the Malpighian bodies, interfering with the function of the kidney. Digitalis causes vaso-motor contraction, producing a flow of urine. The distinguishing mark between digitalis and strophanthus is that both are heart tonics contracting heart fibre, but strophanthus causes vaso-motor dilatation of the arterioles.

Dr. Keene spoke of theoretical and clinical ways of viewing a subject. Many things observed clinically cannot always be explained theoretically. He does not agree with Dr. Jones about the cardiac origin of his (Dr. Keene's) case. There was nothing to point to cardiac trouble. In Dr. Ellis' case it may have been of cardiac origin. He employs several methods of testing urine. He does use the compound jalap powder but could not do so in the case reported because of sensitive stomach. In his case the fœtal movements are violent, to which the mother is very sensitive. An element of hysteria is likely. Are convulsions the cause or the effect of the fœtal movement? He is unable to say. In regard to premature labor, he favors conservatism, hoping to save both mother and child. In regard to morphia he believes rest to be essential.

Dr. Waters asked Dr. Keene if he had used large doses of morphia in similar cases before. Dr. Keene said "Yes." Dr. Waters referred to an article lately published recommending it.

Dr. John Neff said that Loomis recommends it.

Dr. Blake said that all such cases must be treated according to special indications; conservatism if possible, heroic measures if necessary. He likes the hot

wet-pack. If three convulsions come on within an hour, dilate rapidly and deliver.

Dr. Keene was called last summer to a patient of another physician. She was delivered soon in the morning. Later in the day convulsions came on and continued all that night, and some occurred the next day. Dr. W. T. Howard was called in consultation. His prognosis was very unfavorable. He cupped her over the region of the kidney. The patient, however, recovered and is to-day well.

EUGENE L. CRUTCHFIELD, M.D.,
Recording and Reporting Sec'y.

SUMMARY AND GENERAL CONCLUSIONS IN CERVICAL LESIONS OF THE SPINAL COLUMN ATTENDED WITH FRACTURE.

Dr. T. K. Manley, in a paper on this subject (*Med. Rec.*), says:

The general conclusions arrived at after a study of cervical fracture in man and expermental observations on animals justify us in maintaining:

1. Grave injuries of the spinal cord, from injury in the neck, without fracture, are rare.

2. When paralysis immediately follows cervical injury it clearly establishes the fact that the cord has borne serious damage.

3. That the fractures which involve the respiratory centres (from the atlas to the fifth) are almost inevitably mortal.

4. Those below this point are sometimes within the range of operative relief when the apophyses alone are involved; and are not so dangerous to life.

5. Fractures through anterior osseous plane of the vertebral column, the bodies in the cervical and other regions, are not recognizable during life, and are much more common than is generally supposed.

6. The apophyseal type of fracture through the posterior plane is the most easily recognizable, and may be occasionally amenable to surgical measures.

7. Fractures here, as in all other segments of the rachidian structures, are characterized by a tendency to resist displacement, and when this does occur, to spontaneous reposition.

8. The cervical segment of the column may sustain permanent injury without the association of medullary lesions of any description which entail paralysis.

TREATMENT OF INFANTILE CONVULSIONS.

M. Jules Simon recommends the following line of treatment of infantile convulsions: 1. Empty the digestive tract by an enema and by tickling the fauces to promote vomiting. 2. If the attack continues, administer ether or chloroform on a handkerchief. 3. Administer by the mouth, or if necessary by enemata, repeated doses of the following mixture: Chloral hydrate, fifteen grains; bromide of potassium, fifteen grains; syrup of codeine, ten drops; tincture of musk, ten drops; tincture of aconite, ten drops; orange-flower water, three ounces and a half—this quantity to suffice for twenty-four hours. 4. When the attack is very grave, give a warm bath, apply a small blister to the back of the neck or the epigastrium, leaving it on for three hours. Antiseptic precautions should be observed and a poultice subsequently applied."—*Lancet.*

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BALTIMORE, NOVEMBER 4, 1893.

Editorial.

PROGRESS IN METHODS OF DISPOSING OF GARBAGE AND WASTE OF CITIES.

The garbage problem has disturbed the health authorities of all large cities from time immemorial. It is only within a few years back that a practical solution of this problem has been reached. Of the various methods employed for the disposal of this refuse material found in the houses, yards, alleys and streets of all cities, not one has met the requirements so efficiently as the method of destruction by fire. The World's Fair, so proficent in suggestions and in the test of methods of every class and description, has presented a test for the disposal of garbage by fire which goes a long way towards establishing the great value of this method over all other methods hitherto employed.

In a paper recently read before the American Public Health Association, Col. W. F. Morse, of New York, describes the method of disposal of garbage and waste of the World's Columbian Exposition. The method employed consists in the use of two furnaces of the Engle Sanitary Company. Two garbage cremators to burn one hundred tons of sewerage sludge, garbage and stable refuge were erected near the Forestry Building, employing the well-known device of the Engle Company—two fires, one at either end, one burning the mass of garbage on the grates, the other destroying the smoke gases and all results of this combustion.

These furnances have been at work every day since May 5th. The garbage is brought at night from 11 to 8 o'clock A. M., and placed at once in the furnaces. From twenty-five to forty tons of garbage, consisting of every substance collected on the grounds, is consumed daily. Everything goes into the furnace; four horses, two camels, cows, deer, elk, pigs, dogs and goats have been burned with ease. No smoke, no odors, nothing offensive is detected. The fires are oil-fed by jets of air, a pressure of twelve ounces of air doing the same work that is done in the boiler house with one hundred and twenty pounds of steam. The ashes have a value of $10 per ton for fertilizers. There are six burners spraying oil, the whole using 37½ gallons per hour. The cost for fuel and labor is from 75 to 85 cents per ton for sewerage sludge and 50 to 70 cents for garbage.

The cost of combustion may be considerably reduced by bringing to the furnace paper and other combustible material found in city sweepings. The success of the combustion method, as demonstrated at the World's Fair, is as-

sured both as to efficiency and economy and it is only a question of time when all cities will be forced to rely on fire as the chief agency in the destruction of garbage and sewerage sludge.

CÆSAREAN SECTION VERSUS CRANIOTOMY.

The *American Ecclesiastical Review*, Nov., 1893, devotes a large portion of its columns to a discussion of the question of Moral Theology. This subject comprises and combines the natural and divine law, and covers the whole field of moral and religious duty. The science of duty is considered the most desirable, because the most necessary, form of knowledge.

The law of duty has been eagerly sought after from the earliest times, and before the christian era the chief aim of pagan philosophy was to discover it and to give it to mankind. Modern science and philosophy seek to produce the same result. This fact is proven by man's struggle to present "the chief good" for his kind and to establish a mode of conduct which could best secure it.

The study of the question of the Cæsarean section versus craniotomy upon scientific as well as upon moral grounds is an illustration of an effort to bring scientific practices within the strict rule of moral principles. That such an end is worthy of encouragement no humane mind will dispute. The teachings of religion have strengthened this purpose by the vigorous protests which have been made against the brutal sacrifice of infant life in the practice of craniotomy. This procedure has been characterized by one of England's greatest obstetricians, Dr. Radcliffe, as a blot upon English midwifery practice.

The revival of the Cæsarean section and its modifications has shown the inhumanity of a procedure which simply recognized that the life of the woman was paramount to that of the unborn child without considering the possibility of saving both lives by a procedure which involved a maternal risk. A religious, as well as a humane sentiment, gave a helpful stimulus to science in the solution of this problem and the results have shown how duty and science can be made to co-operate in saving human life. At the present day the argument in support of Cæsarean section and against craniotomy is all on the side of the former procedure.

Facts are rapidly accumulating to attest the humanity and scientific accuracy of the Cæsarean operation in contrast with the butchery and the inhumanity of craniotomy. A religious controversy has given place to scientific conviction which stands supported by the authority of facts and results.

Dr. W. H. Parrish, of Philadelphia, has recently summed up the following statistics bearing upon these two procedures.

From craniotomy, Olshausen reports a death rate of 5.7 per cent., Credé reports 8 per cent., Gusserow 8.3 per cent., Leopold about 3 per cent.

From Cæsarean section, Saenger operated 11 times without a death. In Leipzig from 54 Cæsarean operations 3 women died.

In Dresden, from 45 operations 5 women died.

In Vienna, from 30 operations 4 women died. The maternal mortality in all

cases was less than 9 per cent. Of 100 Porro operations 86 women recovered, a death rate of 14 per cent.; 46 symphyseotomies have been performed in Italy since 1885, with the recovery of 44 women and 41 children.

Dr. Parrish asks this question, "Which shall we choose—Cæsarean section with 100 living beings as the result, or craniotomy with about 95 living beings?"

Such results cannot be disputed. They show the influence of moral considerations upon scientific methods which have been able to deal with this problem through the liberal spirit of modern methods of study and investigation.

MR. ERNEST HART'S VISIT TO THIS COUNTRY.

During the present summer Mr. Ernest Hart, the distinguished editor of the *British Medical Journal*, made an extended visit to our country and by reason of the prominent position he holds in relation to the profession of Great Britain he received the cordial hospitality of the profession on this side of the Atlantic.

Wherever Mr. Hart traveled in this country he was welcomed as a distinguished representative of medical thought and principles. His views on various subjects and professional topics were eagerly sought, both by the profession and by the press.

Mr. Hart responded to the requests which were made upon his time by making a number of speeches and addresses before medical bodies and societies, in all of which he took occasion to speak in a frank and straightforward way, not hesitating to express opinions or to offer suggestions which he conceived to be for the best good of the profession.

From a man of decided opinions and fixed convictions, from one trained in one of the very best schools of medical thought and practice in the world, we could hardly have expected any different views from those expressed by Mr. Hart. He saw not a few of the faults and shortcomings of professional methods in vogue here and with perfect frankness spoke of them. He went further, and suggested methods of reform which were apparent to his well-disciplined mind.

For many of his utterances, we regret to say, Mr. Hart has been sharply criticised by one or more prominent members of our profession and by several medical periodicals. He has been accused of having practised the very methods he condemned in us, of seeking newspaper publicity through interviews, portraits, etc., and of having abused our hospitality by passing criticism upon our ethical practices.

After a perusal of Mr. Hart's addresses we fail to see the ground for an attack upon him by a few sensitive gentlemen in our profession who seem to have appropriated his criticisms and suggestions to their particular case. We feel quite sure the great body of the profession in this country entertain no such feelings of resentment towards Mr. Hart It is no reflection upon our profession to be reminded of its imperfections of organization or methods of work. We fall very far short of an ideal position and need the helpful stimulus of a master mind to point the way to higher ideals of work and practices. The profession of the United States may well profit by the manly words of encouragement and

advice delivered by Mr. Hart, whose position as an organizer and leader of professional interests is recognized wherever the English language is spoken or read.

Reviews, Books and Pamphlets.

A Practical Treatise in Diseases of the Skin. For the use of Students and Practitioners. By J. NEVINS HYDE, A. M., M. D., Professor of Dermatology and Venereal Diseases in Rush Medical College, Chicago. Third edition. In one octavo volume of 802 pages, with 9 plates, of which 3 are colored, and 108 engravings. Cloth, $5; leather, $6. Philadelphia, 1893: Lea Brothers & Co.

After careful review of this work we remain deeply impressed with its excellence. The difficult themes of dermatology are treated in a masterly way, so that the reader is at a loss to know which to admire most—the scientific learning and keen clinical insight of the writer, or the delightful flow of his sentences. With the improvements of the present edition it embraces a very wide range of subjects, giving descriptions of all the familiar diseases of the skin and of a great number of rare disorders; and in all points the work is brought up to date.

As a hand-book of dermatology for the student, the general practitioner or the specialist, the work will at once take its place among the very best, if it is not the best, which have yet been put forth descriptive of skin diseases as they are seen in America.

In discussing methods of treatment the author avoids skilfully the two extremes of over-wordy confusion and overbare conciseness, and gives a plain yet complete account of his own methods and those of the best specialists in dealing with each disease. The colored illustrations are excellent, and there are engravings enough to illustrate difficult conditions. The mechanical execution of the work is in keeping with the reputation of Messrs. Lea Brothers & Co.

Medical Progress.

GELSEMIUM IN RHEUMATISM AND NEURALGIA.

In an article with the above title, by Dr. A. Atkinson (Charlotte *Medical Journal*, July, 1893), the author says: "Often the trouble in administering the stronger fluid extracts and tinctures lies in the fact that the alcohol will evaporate and the extractive material will gum up and fall to the bottom and the sides of the bottle, and though you may administer a properly assayed article, you will now and then get too much of the active principle and trouble will follow; then, too, people keep medicines too long and they become uncertain and irregular in their action. It is safe in administering strong drugs, when we can readily procure the alkaloid safely and properly adjusted, to prescribe the article put up by some reliable manufacturer, seeing that it has not been kept too long; and such active drugs are accurately and beautifully put on the market in a soluble form by the Messrs. Schieffelin, of New York), and even though we have a granule which presents all the appearance of freshness and

complete solubility, a good plan is to put it in water a few minutes before administering it, or to stick a hole in it and let the patient swallow it in a half softened state. There is no question but that the gelsemium will afford relief in many cases of neuralgia, but it must be pushed far enough to secure its physiological effects, just short of injury, if we expect to obtain full relief. In facial neuralgia Massini has found that twenty minims every half-hour, for three doses, almost invariably cures. This we would call getting its full effects, one drachm of the tincture in one hour and a half."

MEDICAL EDUCATION IN THE UNITED STATES.

Of Dr. Bayard Holmes gives some interesting data on this subject. He says:

The productive funds in the hands of medical schools, both those connected with and those independent of universities, in theUnited States, was in 1889, $249,200, while at the same time there was in the hands of schools of theology productive funds to the amount of $11,-939,631. The value of buildings and grounds used by medical schools at the same time was $4,047,618, and the theological schools were accommodated with buildings and grounds valued at $7,762,095. The medical schools had in 1889, 12,238 students who paid tuition to the amount of $763,761, while at the same time the theological schools enrolled 6,989 students.

I am able to reinforce these figures by an abstract of the statistics for medicine, theology and technology as reported to the Bureau in June, 1892. The medical schools possessed buildings and grounds in 1892, valued at $7,507,937, and productive funds amounting to$611,-214. Medical departments of the State universities also received State aid in 1892 amounting to $40,500, which, if capitalized at five per cent., would be equal to an endowment of $810,000; making a total endowment of $1,421,-214. There were 16,731 medical students in attendance.

The theological schools report productive funds amounting to $17,599,979, and stated, at the same time, the value of their buildings and grounds was $10,-720,860. They had 7,672 students in attendance.

Technological schools report productive funds amounting to $13,229,940. These institutions received from State appropriations or municipal aid in 1891–92, $747,504, which, if capitalized at 5 per cent., would be equivalent to an endowment of $14,950,080, making a total endowment for schools of technology of $28,180,020. There was enrolled in the schools of technology 10,921 students, about one-third of whom were in preparatory courses. It will thus be seen that the endowment of theology is increasing at the rate of about two million dollars a year. The technological schools are well provided for, but medicine has scarcely raised its endowment, even at the most liberal estimate, to a million and a half.

TREATMENT OF CHOREA.

In a recent lecture, delivered at Charing Cross Hospital, Dr. John Abercrombie makes the following suggestions concerning the treatment of chorea in children: Unless the attack is very mild absolute rest of mind and body is essential. Lessons must be given up and the

child kept at home lying down. Most severe attacks demand complete rest in a bed with padded sides. In very severe cases the child should be slung as in a hammock. Only in the lightest attacks should the patient feed himself. When mastication is difficult, minced meat, milk puddings, milk, beef-tea and coca should form the chief articles of diet. Sleep is of great importance. If necessary, chloral, morphine, bromides, may be administered. Iron and arsenic are the best drugs, though drug treatment is of less importance than general management. Rheumatic manifestations or heart complications should be treated on general principles. In chronic cases douches to the spine, shampooing, massage, and gymnastics, are of value.—*Med. Rec.*

BUT HE CAN'T ADVERTISE.

A physician sits in his office chair,
And there broods on his face a look of care
While he groans and wails and tears at his hair.

"Alas! and alas! and alack!" he cries,
"Surely fortune and fame would both arise
If Old Ethics would let me advertise."

At last a bright thought comes into his brain;
Says he: "I must try that old racket, 'tis plain;
It worked O. K. once and I'll work it again."

He wrote half a page on "The Evils of Pork,"
And the case of a man who swallowed a cork
And a spoon and a knife, but got stuck on a fork;
Told how he cured an imprudent fellow
Who swallowed entire a gingham umbrella
And brought it intact from the patient's patella.

The newspapers all extended their thanks;
He opened accounts at the various banks;
He'd baited with Ethics and caught all the cranks. —*Printer's Ink.*

CATARACT EXTRACTION WITHOUT IRIDECTOMY.

In his Bowman lecture (*Lancet*, June 17), Dr. Teale, after describing in particular his own method of procedure, gives the following summary of his theme:

Having been for many years convinced that for all but exceptional cases an operation involving iridectomy is not the best method of extraction of hard cataract, it has been a matter of interest to observe the increasing tendency of ophthalmic surgeons to move towards the same opinion. One of the earliest ophthalmic writers in England to publish a series of operations by a shallow flap without iridectomy was Mr. Snell, of Sheffield, who was my assistant and house surgeon in 1870-72 at the time when I was beginning to adopt the shallow flap and to abandon iridectomy. He tells me that of his last 200 extractions at the Sheffield Infirmary there were but thirteen combined with iridectomy, of which ten were preliminary to Forster's operation for immature cataract and two or three were accidental at the time of operation. In 1885 Galezowski began to operate without iridectomy. Of 1365 cases reported 1173 were without iridectomy,

179 with it and 13 with sphincterotomies (division of the circular fibres of the iris). In 1886 Knapp, of New York, began a series of operations without iridectomy, reporting 450 "simple extractions," against 371 cases "with iridectomy." In 1888 Professor Schweigger, of Berlin, began to abandon iridectomy, reserving it for special cases. Of 465 operations 400 were "simple extractions." DeWecker, of Paris, writes in November, 1892, on "simple extraction" and the "combined operation." He says: "The extraction of cataracts with iridectomy is not—and M. Fuchs, of Vienna, agrees with us—the safest." . . . . The "safest to avoid a large prolapse; yes, but there its advantages cease." He lays down the rule that "with a perfectly ripe cataract in a healthy patient simple extraction is the proper" operation to perform, but if "the cataract is not ripe, or the hygienic conditions are unfavorable, an iridectomy should accompany or precede the extraction." On the other hand, Landolt, of Paris, having written to a large number of ophthalmic surgeons to ascertain their views on extraction of cataract at the present date, sums up in favor of extraction preceded by iridectomy. It is clear the confidence of ophthalmic surgeons in iridectomy as an adjunct to extraction is being seriously shaken and that opinion is ripening in the direction of some form of simple extraction. The operation of so-called "simple extraction" to which some have reverted is apparently the old semilunar flap with the incision close to or even within the sclero-corneal junction. It was in order to obviate the disadvantages of this "simple extraction" that Graefe invented his "linear extraction with iridectomy." It would seem, however, from published records, that even with all its disadvantages the simple extraction by semilunar flap without iridectomy attains results equal to those obtained by Graefe's operation; but the exact method of operation which I am advocating differs essentially from both of these in that the incision is entirely within the cornea, almost linear, and yet without iridectomy. If I am right in advocating a method of operation which I have tested for so many years and which has been attended in a very large proportion of cases with most satisfactory results as to vision and comparative freedom from complications, as well as regards perfection of scar, pupil and anterior chamber, I cannot but think that a surgeon who would give a full trial to the method described and the rules laid down would surpass, in visual results and in freedom from complications, his former successes with either the so-called "simple extraction" or the Graefe operation with iridectomy.

TREATMENT OF ACUTE AND CHRONIC RHEUMATISM.

For the last six years M. Ruel has treated externally only acute or chronic rheumatism. Compresses steeped in the following solution are applied twice a day to the articulation, and covered with oil-silk so as to prevent evaporation.

℞.—Salicylic acid . . . . 3 v.
Proof spirit . . . . ʒ iij.
Castor oil . . . . . 3 vij.
Chloroform . . . . 3 iv.

When the applications are properly made the salicylic acid appears in the urine twenty-four hours after.—*Medical Press.*

POISONING BY DIACHYLON TAKEN TO PRODUCE ABORTION.

Two interesting cases of this nature, occurring in the same town, are reported in the *Brit. Med. Jour.*, July 1, by Dr. Pope, of Leicester. We quote one in full:

A. W., aged 22, married, hosiery hand, admitted August 2nd, 1892. She was anæmic; the skin and conjectivæ were of yellowish tint. She seemed of weak intellect, though not formerly so; had a fatuous expression, and would not speak above a whisper. She complained of pain in the abdomen, principally in the right iliac fossa, and attributed her symptoms to a miscarriage which occurred in May last. Her health before her marriage, three years since, was good. She had had two children, both of whom died in infancy, and two miscarriages. At the last in May, 1892, she lost a good deal of blood, and since that time had been suffering from pains, and had no return of menstruation. There were no abnormal signs in the lungs, heart, or abdominal viscera and no signs of syphilis. There was pain on pressure over the hypogastrium. The bladder was distended. On vaginal examination nothing abnormal was found. The rectum was loaded with fæces. The urine (specific gravity 1015) was of a dark reddish color, but contained no blood, albumen, bile or sugar. The limbs weak, but she could move them all; the deep reflexes absent, sensation unimpaired. The bowels were relieved by enema, and the urine was then passed naturally. After remaining in about the same condition for a week, she had an epileptiform convulsion on the night of August 8th. The tongue was bitten; the bladder found again distended. On the morning of August 9th there was complete loss of power in the arms and legs and fæces were passed involuntarily. The condition was thought to be due to either tuberculous meningitis, or a cerebral tumor. On August 10th she had several more convulsive attacks, was continually crying out, and rolling her head from side to side. The paralysis had extended to the diaphragm; this caused suspicion that her condition might be due to peripheral neuritis, and inquiry was made from the friends as to the possibility of diphtheritic poisoning but no history of sore throat could be elicited. The faradic current was applied to the diaphragm, but she died at 8.45 A. M. on August 11th.

Necropsy.—The brain was carefully examined, and nothing abnormal could be found. All the organs of the body were found healthy, with the exception of the intestines, which were contracted and contained a yellowish sticky fluid in considerable quantity. There was no corpus luteum in either ovary. There was a well-marked blue line around the gums, which had been inconspicuous before death.

Death was considered to have been due to lead poisoning, and an inquest was held. An aunt of the deceased gave evidence that some weeks before her death the deceased had pointed out a chemist shop and said "That's where I get the stuff I take," and in answer to a further question as to what stuff she meant, replied "Diachylon." Witness said, "I thought that was poison," and deceased answered, "Well, it does not poison me. I get two pennyworth and make it into pills, so I can swallow them." She also gave witness to under-

stand that she took it with a view of producing abortion. Under the direction of the coroner the verdict of *felo-de-se,* by taking a drug for a felonious purpose, was returned.

CHANCRES ABOUT THE NAIL.

There is a class of ulcers about the nail which are syphilitic, and unfortunately they are most apt to assail members of our own profession. The number of doctors who get poisoned by a slight agnail, and chancre at the root of the nail, is large. Unfortunately, unless the physician is on his guard, he neglects it and thinks it is a simple whitlow; wonders that it does not heal. He poultices it. It is purely a specimen of hard chancre.

It refuses to heal under any treatment. Soon after that a gland is felt at the elbow and up the arm; and later syphilitic roseola appears on the body and the diagnosis is clear. I mention this, because I have seen quite a number, and heard of a great many more such cases, of a suspicious sore about the nail, in practising physicians. If it were my own case I should promptly take mercury, after such a sore appeared on me. That speedily settles the diagnosis. The moment the patient is slightly merculiarized, the sore softens and begins to heal.—Dr. D. W. Cheever, *Boston Med. & Surg. Journal.*

A HOSPITAL NEEDED.

That great and ancient city, Damascus, has no hospital for its population of nearly two hundred thousand souls. A successful dispensary has been conducted by the Edinburgh Medical Missionary Society since 1887. It is at present under the charge of Dr. Mackinnon and Dr. Scott Smith. These gentlemen have an Imperial firman granting them power to proceed unmolested in their work and to erect a hospital. The movement is in an initial stage, and the dearth of vacant houses makes the choice of a situation very difficult. If they are obliged to buy land and erect a hospital for sixty patients, together with a dispensary, they estimate that $25,000 will be required. There is an old saying that where the Englishman would build a fort the Frenchman will erect a theater and the Spaniard a monastery. To this we are tempted to add: and the Scotchman a hospital.—*N. Y. Med. Jour.*

DAMAGES ARE RECOVERARLE FOR INJURIES RESULTING IN MISCARRIAGE.

When a married woman is so injured by the negligence of a person as to miscarry, her husband can recover damages for the loss of the child. So holds the Superior Court of New York City, General Term, in the case of Butler *vs.* Manhattan Railway Company. Here was an action brought by the husband to recover for injuries sustained by his wife, who was struck in the side by the gate which the train guard was closing. Damages were assessed by the jury in the sum of $2250, which was approved on the appeal. It is also to be noted that it was contended that the trial judge erred in excluding the testimony of two physicians as to what the woman told them of her physical history when they treated her at the Women's Hospital, inasmuch as by testifying to these facts herself she waived her privilege of excluding the physicians' testimony.

The Court, however, held otherwise on this point, especially because when asked about the statements made at the hospital, she had only said that they gave her two doses of medicine for her nervousness, and she did not know what statement she made after that. One of the doctors came to take her statement, but she did not recollect what she said. From this the court held that it could not be said that the witness opened the door of the consultation-room to the jury and undertook to give them a statement of what occurred between herself and the physician.—*Med. News.*

Medical Items.

Under the will of the late Charles B. Beck, the New York Hospital will probably receive about $200,000.

The Congress of Norwegian Physicians, which recently met at Christiania, held its sessions on a large steamer which moved from place to place. The physicians were thus furnished with fresh air and change of scene while pursuing their scientific work. The example is worth studying and following. Hereafter, instead of hiring a hall for their midsummer congresses, let them hire a boat.

The will of the late Dr. Parsons, of Providence, bequeathes his medical library to the Rhode Island Medical Society, and four thousand dollars to the Rhode Island Hospital, to establish a free bed in memory of his father, Usher Parsons. The residue of the estate, after paying all of the bequests, is to go to the Rhode Island Hospital. The estate is reported as very large.

On October 26, 1768, the Empress Catherine II submitted to innoculation, being the pioneer of the practice in her own dominions. The preparations for the novel function were most elaborate. The lymph was supplied by a boy of seven years of age named Markof. This boy was ennobled under the fancy name of Ospiennyi (ospa=small-pox) and brought up under the Empress's own tutelage. His descendants occupy at the present day a prominent position amongst the Russian aristocracy.

The late Mrs. Mary T. March has bequeathed $10,000 to Bellevue Hospital in memory of Charles March; $10,000 to the Louise Home of Washington, D. C., in memory of the mother of the deceased, and the remainder of the estate to Grace Church, in New York, for the purchase of ground and the erection of a hospital, to be known as the John Pyne March Memorial Hospital for the relief of the sick, aged, and indigent in Grace Church parish. The total estate amounted to about $1,000,000, and the greatest part of this sum goes to the new hospital.

Dr. Arabella Kenealy, the author of "Dr. Janet of Harley Street," a novel which has reached a fourth edition, is said to have entered the medical profession with the express intention of bringing its resources to bear upon fiction. Having showed considerable literary talent at a very early age, the burying herself in medical student life for the lengthy period over which the attaining a degree extends was regarded by her

acquaintances as a waste of time. But Miss Kenealy is convinced that the time could not have possibly been better spent; that for the study of human nature and a thorough realization of some of its most suggestive phases, the life of a doctor is pre-eminently fitted.—London Cor. *American Practitioner.*

The College of Physicians of Philadelphia announces that the next award of the Alvarenga Prize, being the income for one year of the bequest of the late Senor Alvarenga, and amounting to about one hundred and eighty dollars, will be made on July 14, 1894, provided that an essay deemed by the committee of award to be worthy of the prize shall have been offered. Essays intended for competition may be upon any subject in medicine, but cannot have been published, and must be received by the secretary of the college on or before May 1, 1894. Each essay must be sent without signature, but must be plainly marked with a motto, and be accompanied by a sealed envelope having outside the motto of the paper, and within it the name and address of the author. It is a condition of competition that the successful essay or a copy of it shall remain in possession of the college; other essays will be returned upon application within three months after the award. Charles W. Dulles, Secretary.

The following story is told by the *Medical Herald*, at the expense of the genial Dr. F. C. Hoyt, superintendent of the insane-hospital at Clarinda, Iowa, who has been doing the World's Fair recently. One of the chief attractions for him in the Midway was Hagenbach's "trained animal" show. He is noted for his sympathetic nature, and after witnessing the performance, sought an opportunity to converse with the lion-tamer. After a few preliminary inquiries as to the disposition of the animals, the doctor proceeded to sympathize with the king of the den concerning his lot, isolated as he was from civilization, and compelled to associate entirely with the wild beasts. Doctor Hoyt digressed eloquently upon the uncertainty of life, and expressed his great satisfaction at not having to play with the monster lion, who was nervously pacing his cage and growling. The keeper listened attentively, only remarking that he was "used to it." When the doctor turned to depart, the "king" courteously asked for his card. It read: "Iowa Hospital for the Insane." "Great guns!" gasped the tamer, "I wouldn't trade jobs with you for a million dollars."—*Medical Standard.*

On the evening of October 27th the buildings of the University of Maryland, corner Lombard and Greene Streets, were thrown open for inspection. Extensive improvements, begun during the summer, have been completed. The grounds and buildings have been remodeled and altered to such an extent as to give a very attractive appearance to the old institution which has stood for so many years as a landmark in the city. A third story has been added to old Practice Hall, with all necessary appliances for a dissecting room. The second story of the building has been equipped as a laboratory for histology, pathology and bacteriology, whilst the first story, which is so well remembered by the graduates of the University, has been converted into a chemical laboratory. The other improvements consist in en-

largement of Practice Hall by an extension back to the alley, repainting and repairing of the old University building, removal of large brick wall around the grounds, to accord with other changes in the grade of the lawn. Altogether the improvements are as handsome and attractive in appearance as they are useful in design and arrangement for advanced methods of instruction.

At a meeting of the Philadelphia County Medical Society, held October 18, 1893, the following resolution was unanimously adopted:

Whereas, Dr. Jas. E. Reeves, of Chattanooga, having denounced the so-called "Amick Cure" for consumption as a quack nostrum, and stated that its proprietor was not a physician in good and regular standing, was accused of criminal libel; and *Whereas,* The grand jury has ignored the indictment brought against him, be it

Resolved, That the PhiladelphiaCounty Medical Society congratulates Dr. Reeves on his bravery, a bravery unfortunately too rare at the present day, and tenders him sympathy in the persecution to which he has been subjected ;

Resolved, That no person who makes, deals in or advertises as a cure a quack nostrum, that is to say, a preparation the composition of which is kept secret, can be termed a physician in good and regular standing, because such action is *ipso facto* sufficient to cause forfeiture of membership in this or any other County Medical Society governed by the laws of the American Medical Association.

Resolved, That a copy of these resolutions, duly attested with the signature of the President and Secretary and with the seal of the Society, be forwarded to Dr. Reeves, and that they be handed to the press for publication.

Many of the graduates of the University of Maryland of a dozen or more years back will recall the person and character of old Anderson Perry, colored, the janitor. "Old Perry" was a sailor by occupation. As far back as 1876 he was admitted into the University Hospital suffering with hemiplegia. For many months the use of his left side was completely gone, but by degrees he regained motion and was able to hobble about the wards. From time to time he made himself useful in waiting on the other patients until finally he was regularly installed as ward master of the colored male ward. Here he did good work for several years. He subsequently drifted from the hospital work to the college and became an assistant in the dissecting room. Here he served for several years, until he became implicated in the murder of an old woman named EmilyBrown, who lived in Pig Alley, whose body was brought to the dissecting room by Wm. Ross, colored, whilst still warm, after her murder. Perry denied his knowledge of the murder and on the trial of Ross, who was convicted of the crime, he was able to prove his innocence. He was, however, believed by many to be a party to the crime and was ever after held in great fear by his own race, whose superstition aroused hatred and prejudice against "Uncle Perry," as he was afterwards called. From our knowledge of Perry, we believe him to have been an innocent and harmless old negro and in no way responsible for Ross's crime. Perry died a few days ago at the Bay View Almshouse, hence our comments at this time.

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TREATMENT OF PSORIASIS.*

BY J. ABBOTT CANTRELL, M. D.,

Instructor in Dermatology in Jefferson Medical College, Philadelphia: Dermatologist to the Philadelphia and St. Agnus Hospitals, Philadelphia.

While psoriasis does at times respond quickly to treatment, we may often see it when the best improvised remedies will give no relief and then it will tax the mind of the most experienced.

The treatment as a whole is as successful as the remedies are correctly chosen, and whether in the hands of a novice or those of the more experienced the result wished for will certainly be obtained.

The treatment must necessarily combine systemic as well as local combatants, and those chosen must be strenuously followed out to the very letter.

After the treatment of over 1000 cases I certainly feel that we have no one remedy upon which we can safely rely, and one of the drugs at least which has been looked upon as a specific can not hold the place which was formerly given to it, and while it will retain its merits in one condition of the disease, in others we will be obliged to carefully scratch our heads and think.

Arsenic.—While formerly this drug was known as a specific and while now possibly a very safe remedy has been used in the treatment of this affection for some time back and while the results may not justify its continuance in one form, it would be advisable to change it to some

*Read before the J. M. DaCosta Medical Society, Nov. 10th, 1893.

other of its preparations before changing the drug entirely.

The preparations of this drug which are advisable for the treatment of this affection are, possibly, liquori potassii arsenitis, liquori potassii et hydrargyri, iodidi acidi arseniosi, arsenici sulphidi, sodii arseniatis, ferri arseniatis.

Liquori potassii arsenitis.—Will best be given with a dosage of gtt.iv to begin with in the adult and gradually increased one drop each day until you get as near the characteristic effect as possible without really getting it; or another plan is to begin with the same dose and increase one drop each day until gtt.x is reached and then drop to the original dose and increase again to the maximum, and thus rising and declining for an indefinite period. This preparation is in my opinion the best of the arsenic group.

Liquori potassii et hydrargyri iodidi. —May be used in the same manner as the Fowler's but you are likely to get the characteristic effect sooner, a condition which is not advisable to get too soon in the treatment of so chronic a disease. I do not think it near as good as the former preparation, but some writers claim it an efficient one simply because of the diuretic effect of the potash salt.

Acidi arsenici.—Is a desirable remedy in some forms of the disease simply because one meets those who can not or who will not take medicines in a liquid form, especially those who have been under treatment for some time.

It may be given in doses ranging from gr. 1-60 to gr. 1-30 and increased to gr. 1-10 or even gr. 1-5 in some rare instances—or it may be given in increasing doses as in the first preparation.

Arsenici sulphidi.—I have given arsenic in this form in a number of instances with benefit. I usually begin with a dose of gr. 1-100 in pill form given three times a day and increased until 24 pills are taken in the 24 hours and then continuing at this dose for a period of 2 or 3 weeks and then if found that the remedy is not having the desired effect it will do to increase until 36 pills are given in the 24 hours, but it is in only rare instances that I have ever been called upon to increase to a higher dose than this.

Sodii arseniatis, ferri arseniatis.—Have been recommended by Biell and he has much to thank them for in the treatment of his cases. They may be given in doses of from gr. 1-12 to gr. 1-3 three times a day; you may begin with the smaller dose and increase in the same manner as with the former preparations, but I would call your attention to watching them carefully, as I think them unstable.

The arsenic group has been found to give better satisfaction in those cases which are acute or in those of the chronic variety which have never been under the use of the drug. In those cases which have been under treatment before with this drug better results will be obtained by beginning with some other remedy.

Olium morrhuæ and its preparations are given with good results in that class of individuals who are constantly found in our asylums and city hospitals, and it seems to give more relief than anything else, but there is another and more important class of persons who may be benefited by its use, and they are the cachetic and strumous and possibly in those who are tubercular. It is also a

drug on which we may rely if at any time it should be necessary to make a change in medicines. The doses given may be large at all times.

Turpentine.—The oil of turpentine is the most used and is found of service, but unfortunately the drug itself is very obnoxious to many persons, and those who wish to be relieved of this affection think that the disease is by far the minor evil. Doses ranging from gr.v to gr. x in capsules or on sugar may be given three times a day.

Olium copaiba, recommended first by Hardy, has been used by me in about 100 cases and I do not think the results could be better; the dose is generally given in capsules three times a day after meals. The results from the use of this drug certainly justify its trial in more cases, and I think it would be an advisable treatment to begin the treatment of many cases.

Other remedies and conditions are recommended and are said to influence the disease.

Tar is recommended by McCall Anderson, and in this he is followed by Kaposi, Thin and others. Sulphur is also mentioned by the former of these gentlemen. Chrysarobin was first mentioned by Squire in 1876 and followed by the recommendation of Fox, of New York. Antimony in the form of vinum antimonii tart. is referred to by Malcolm Morris. Cantharides and phosphorus are mentioned by Crocker. All of these foregoing remedies have given good results in some cases while in my hands.

Hypodermics are spoken very highly of by some writers and when used it is advisable to employ the colorless Fowler's solution or the arsenious acid. My impression is that it will be better not to employ this manner of treatment until everything else has failed, simply because people will object to it in most instances.

Diuretics are recommended by some writers; in fact, they are beneficial in all cases where there is a gouty or rheumatic tendency; the acetate potassium in large doses, liquor potassi, first recommended by Robinson. Carbonate of ammonium is preferred by McCall Anderson.

Diet is said to influence the disease to some extent and Passavant, of Frankfort, said that in 1867 he had cured himself by Bastingism (i.e., by a meat diet) after everything else had failed.

Local measures certainly play as important a part in the cure of this affection as internal medication, and one class is directed for the removal of the scales, and pave the way for the second and more important class, those advised for the cure of the disease.

And after the scales are removed, if the second class do not assist in the cure of the disease they certainly alleviate the condition.

The removal of the scales may not always be an easy task, as sometimes very strong applications are demanded.

Carbonate of soda and carbonate of ammonia, the latter my preference, are placed in a bath of 30 gallons in the proportion of ℥ii to ℥vi to the bath, and the patient allowed to remain in it for a period of 30 minutes, and if the scales are abundant, an attendant should scrub him by means of a stiff brush, taking care not to irritate the skin too much.

Other means may also be employed

to reach this condition, and they include wet packs, or inunctions of some oily or fatty substance; olive oil may be found satisfactory; saponis viridis of the Germans is an admirable remedy, but care must be exercised or decided eczematous symptoms may arise, and thus complicate the original disease.

After the removal of the scales, we have a more important class of remedies which are directed to assist in the cure of the disease.

Some of the mercurial preparations may often be used advantagiously; those of this group most advisable are the hydrarg. ammonii chlorid. or the hydrarg. ox flava; either of these may be used in the proportion of gr. x to ʒii to ʒi of ointment.

Of the tar preparations, may be mentioned the ungt. picis liq.; this, according to my plan, is rubbed in three or four times a day if the patient will submit.

The oils—cade, fagi, rusci, and creasote—may give good results in the proportion of ʒss to ʒss or ʒi of ointment.

It may be preferable to use a lotion and then the liq. carbonis detergens may be ordered mxx to ʒi to the ʒi of water.

Tar baths have proven satisfactory.

Naphthol and thymol may be used if the skin of the individual is tough.

Chrysarobin, recommended first by Squire in 1876, gr. xv to ʒss to ʒi of ointment, has given good results in my hands.

Acid pyrogallic, referred to by Jarisch, may be used in some instances, but my impression is that it is not as good as the former preparation.

Anthorobin has been referred to, but it will not take the place of chrysarobin.

Oleate of copper, ʒss to ʒii to ʒi is advised by some writers.

Wilkinson's ointment, modified:

℞.—Olium cadini.
Sulphuris sublimat. . aa ʒiv.
Saponis viridis. . .
Adipis. . . . . aa ʒii.
Cretæ preparata ʒiiss.—M.

This may be used full strength, but often you will meet with skins that will not stand it, and then half of that will generally be of service.

Sulphur baths are recommended very highly by some writers.

Watering places, such as Bath, Harrogate, Buxton, Strathpeffer in Britain, Leuk, Aix-La-Chappelle, Kreunach, La Bourboule on the Continent. These act mainly by removing the scales.

La Bourboule and Royat contain arsenic.

These and other baths must be indulged in for from 4 to 8 hours.

1010 S. 3rd Street.

The value of negative information was well stated by the famous French savant who was once asked by a certain lady an apparently simple question in science. He replied, "Madame, I do not know." "Well, what is the use of all your scientific education if you cannot tell that?" said she. "Madame, to be able to say I do not know," he replied. —*Medical Times.*

Professor Hans Virchow has been appointed Senior Prosector in the Anatomical Institute in place of Professor Hartmann, deceased.

SURGICAL TREATMENT OF CRIME.*

BY E. TRACY BISHOP, M. D,
SMITHSBURGH, MD.

Law is a curious business and lawyers, according to Nancy Jones, are "curus man-critters," mostly.

If a case comes into court (the hospital for the care of social maladies being so-called) for treatment for curative or preventive results and a remedy should be proposed altogether rational and promising, its use is not permitted by the learned judge until a precedent for it has been discovered. Then the counsel in the case turn over the pages of legal lore to the times when people did not seem to know much of their own affairs and if they find something like the case in hand (like it because it is not like anything else) then they employ it as a remedy—not otherwise. Under such circumstances it is hardly matter for wonder that the disease keeps ahead of the remedy, or that the law's delay should be a proverb and a threat against honest business. It is not so in medicine. If a physical malady occurs, all scientific methods are at once invoked to discover its nature and an efficient remedy and preventive. Chemistry, microscopy, physiology, are all employed. The profession everywhere is enlisted in the investigation. One doctor is never employed by anybody to defeat the honest efforts of another. Under such conditions it is hardly marvelous that there should occur marvelously contrasting results. In court, in equity cases, so-called, the chances are largely with the rogue.

Crime of all kinds is on the increase, our jails and almshouses and other asylums are filled with its products. Lynch law cases (the signal lights of lost confidence in courts of justice) are flashing everywhere every day. And every-day business transactions are largely based on individual integrity.

On the other hand, it need only be mentioned that the average of human life is being gradually raised. Not only that, however, but all the deadly diseases of the past are under virtual control.

Population is no longer decimated. People no longer fly in insane fear from house and home at the approach of cholera or yellow fever where medical men hold sway.

Seeing that these things are so, would it not be wise for the one profession to borrow the methods of the other? Nay, would it not be even better to profit by both their example and assistance?

The medical profession have long since shown that criminals are of germ origin, some peculiar character or condition of the spermatozoon resulting inevitably in the production of a criminal. The saying, *nascitus non fitis,* is as true, therefore, for the criminal as it is for the poet. Now, the doctors have found that the true way to prevent diseases of germ origin is to prevent the germ and if the law wants to prevent criminals the sure way to do it is to sterilize the parent criminal and the only way to do that is to castrate him. Of course there will be a thousand objections urged against the remedy, only two of which will be worth answering. One will be cruelty, the other danger to life, both of which are already negatived by anæsthesia and asepsis. Doubtless there will also be the epithets "uncivilized" and "unchristian"

*Read before Medical Society of Washington County, Maryland, Aug., 1893.

applied to such treatment. But how will prevailing methods of treating criminals compare with this? Now they are penned up together to fester and ferment into more and more repulsive and dangerous criminal forms, the petty thief emerging in the form of a daring robber and the robber in the shape of a murderer.

The practical effect of it all is the production of murderers by cultivation and breeding and the subsequent slaughtering of them by hanging. The thief, especially a bank thief, is imprisoned until the baby is weaned; but the spots of the leopard change not and the thief remains a reproducing thief in spite of legal punishment. How simple and how clean and how effectual the germicide method. You destroy the germ factory of the thief and so reform the thief himself more surely and effectually than all the prayers of the righteous would do it (How common is the practice of curing a vicious stallion by castration?) and prevent the production of thieves. If you do not breed thieves you will not have them.

We owe it to the old English custom of hanging thieves that we now are as well rid of them—more than we owe it to moral suasion.

One curious result of the treatment would be the settling of the race problem. I think it is statistically stated that 75 per cent. of the crimes committed are by "the nation's wards." If that is so the application of the treatment would rid us of several millions of fertile negroes. We owe it to the colored race to apply it promptly and rigorously. It was a wrong to the race to free them so soon. If they could have been held for a few more generations as slaves and bred as hitherto for their moral and physical points they would have outstripped their breeders in these things. As they are now they are even less careful in mating than their white neighbors and consequently they are rapidly degenerating. Worse than all, they are fast becoming a social plague and a horrible danger to innocence and morality.

Castration would hardly be a hardship to the negro. It has been practised upon members of the race for all time. The harem of the Turk is always supplied with negro eunuchs. Why they were selected we may never know. Possibly it was because there were individuals who could be restrained in no other way. Of course a law declaring all crimes not punishable by death shall be punished by castration would not be tolerated by the constitution as it is now written. But a law could be enacted punishing all slighter crimes by an exceedingly severe flogging, but releasing the criminal upon his producing proof of recent castration. There is a Japanese law which secured the destruction of State offenders by restoring to the family the estate if they could prove that the offender had committed suicide. Truly wonderful is aseptic surgery; it enables us to literally obey the scripture which enjoins us to cut off the offending member. It is of course taken as understood that lady criminals are meat also, it being as easy to cure one as the other.

There are at present 131 women registered among the students of the French Medical Schools; of this number, 95 are Russians.

THE TREATMENT OF INCOMPLETE ABORTION.*

BY J. M. HUNDLEY, M. D.,
Chief of Clinic Diseases of Women and Children, University of Maryland.

I do not think I need offer an apology for bringing before you to-night the subject of the treatment of incomplete abortions.

From my personal experience, the complications arising from incomplete abortions give us a very large percentage of the various gynæcological cases seeking the aid of the specialist. Such should not be the case and will not be where the proper treatment is pursued and at the right time. This short paper is only intended to deal with abortions after the rupture of the sac. Prior to the rupture and escape of fluid, the case only needs to be let alone. The membranes should be kept intact; if an examination be made it should be done with the utmost care.

In November, 1886, I was called to see a woman whom I found bleeding profusely. It was clearly evident after a hurried investigation of the case that the hæmorrhage was due to an incomplete abortion.

She had probably been pregnant about three months. The cervical canal was dilated to nearly the size of my forefinger, and yielding. And I might here remark that where there has been much bleeding in these cases I have very generally found an easily dilatable cervix.

The woman had lost a great deal of blood and was in a bad way. I at once took a large-size curette and attempted to scrape away the placental tissue. At about the end of the third month we have the placenta fully formed. How well I succeeded I am unable to say. I got away some of the mass and the bleeding greatly diminished. The woman died in three days from septic peritonitis, the result, most likely, of injudicious treatment. I cannot believe that any man, however skilled, can differentiate the various structures in a puerperal uterus at the end of a curette.

The inference to be drawn, therefore, not alone from the above case, but in others where the end aimed at was the arrest of hæmorrhage and failure the result, is that the finger is the only justifiable curette in a puerperal uterus. There are many with whom I have talked who say they have tried to introduce the finger into the uterus for the purpose of removing adherent secundines and have never succeeded. All that is necessary is a determination to succeed and gentleness in manipulation. I am willing to admit that there are cases where an anæsthetic may be necessary to enable us to grasp the uterus and force it down within reach of the finger. I have used a double tenaculum fastened in the cervix to draw down the uterus.

If the cervical canal is not sufficiently dilated to allow the entrance of the finger and there be much bleeding, the vaginal tampon may be used or rapid dilatation resorted to. I cannot see why one is willing to grope blindly about in a uterus with a curette when the finger can do the work far more intelligently and satisfactorily.

Some three years ago, in attempting to scrape away with a curette a bit of adherent placenta, I penetrated the uterus; fortunately no bad result followed the accident. Since then I have

*Read before the Gynæcological and Obstetrical Society, October, 1893.

never used a curette within a puerperal uterus. With a clean finger and a moderately long nail you have the ideal curette for these cases.

Time and again I have known operators to fail to arrest bleeding due to retained placental tissue, etc., simply because the curette failed to come upon the mass that caused the bleeding.

Not only does the curette in intelligent hands fail to remove all of the adherent placental tissue, but there is always a liability of going through the uterine wall; and even where that does not occur we scrape about blindly, sounding the proper structure of the uterus, and thereby give a surface which can be freely invaded by micro-organisms.

There are physicians in our city with large practices who tell me that they have never curetted a uterus after incomplete abortions and never lost a case from abortion, save criminal abortions, and that they treat every case with ergot and rest. That may seem incredible to those who upon the slightest provocation resort to the curette. I will venture the assertion that there would be fewer pus tubes, less pelvic peritonitis and deaths, if the uterus was emptied of its contents by a clean finger. If the case be seen within a few hours of its inception, I do not deem it necessary to use an intra-uterine douche.

I might cite case after case, in my own personal experience, to illustrate the immense advantage one has in the use of the finger over that of the curette. Of one only I will speak. Four weeks ago I was called to see a woman with this history.

Mrs. E., 36 years of age, widow of six months' duration; two months prior to my visit a physician had been called in, and it was upon his solicitation that I was called to see her. He told me the woman had been bleeding about two months, and at times passed what looked like pus. He had seen the pus, but not the blood. She was anæsthetized and upon examination the uterus was found to be about the size of the organ at two-and-a-half months' pregnancy. The cervical canal was patulous, but dilatation had to be resorted to to allow my finger to get within the uterine cavity; as soon as that was accomplished the case was made perfectly plain; she was the subject of an incomplete abortion. The membranes had been ruptured and had begun to suppurate; at the placental site there was firm adhesion, and strange to say, the fœtus was still within the uterus, suspended by the cord.

Recapitulation.—Given a case of incomplete abortion (and by incomplete abortion is not meant a few shreds, etc., retained within the uterus, but the entire secundines remaining), what is the best treatment? In my opinion it is the introduction of the finger; with it an intelligent understanding of the case is obtained, and at the same time the secundines can be easily removed. There is no haphazard work; you know just what you are doing. If the uterine cavity is too small for the manipulation with the finger it is self-evident that what remains behind is of insignificant amount, and if necessary may be removed with a curette.

The point I wish to make is that, when the secundines of a $2\frac{1}{2}$ or 3 months' pregnancy are retained within the uterus the finger is the best means of removal.

If there be only shreds, etc., the curette can be used. To ascertain this point, the approach of the uterus to its original size must be one source of informations; the other, the introduction of the finger within its cavity; or to use the curette blindly and trust to luck for the efficient performance of the operation.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD NOV. 3, 1893.

The 284th regular meeting of the Clinical Society was called to order by the President, Dr. J. Edwin Michael.

Dr. Hiram Woods related a case of CICATRICIAL CLOSURE OF THE EXTERNAL AUDITORY MEATUS, and exhibited the patient.

The patient, a white man, aged 35, during the fall of '87 became involved in a quarrel with some one in the same house. Sometime after, while sleeping, his enemy entered his room and poured sulphuric acid in his left ear. Suffering terribly, he at once sought medical advice from some one near him. Dr. Woods saw him three weeks later and found the canal filled with granulating tissue, foul suppuration going on, and the parts too sensitive to bear examination. Chloroform was administered, the canal scraped, and it was seen that the drum-head was gone and the ossicles apparently burned out. Treatment, with view of keeping canal open and clean, was adopted.

Suppuration continued. Occasionally the patient would suffer with severe pains which could be relieved by scraping the canal. Gradually contraction of the external portion of the canal took place and cicatricial tissue formed over the meatus. Whenever the pain became great an incision through the cicatrix would permit the flow of pus and give relief. This was the course for two years. Finally the discharge ceased, the meatus closed up entirely, and for four years the patient has had no pain. There is no perception of sound save for the fork by bone conduction. There is evidently an opening through the external auditory canal, for inflation by Valsalvan method produces a perceptible motion of the scar tissue at the opening of the canal. Dr. Woods thinks that to have permitted healing to take place there was probably drainage through the Eustachian tube.

Dr. N. G. Keirle read a very interesting paper entitled "Preliminary Report of Certain Experiments Concerning Certain Aspects of Rabies."

Dr. L. McLane Tiffany related two cases bearing upon RENAL SURGERY—one from his own practice, and one from that of Dr. Johnson, of Richmond, Va.

Case I.—Adult, male negro, having all the clinical symptoms of pulmonary tuberculosis. Was suffering extreme pain in the bladder, frequent micturition, urine cloudy—no blood. Opened the bladder above the pubes and introduced a tube. There was no relief. One month and a half later Dr. Tiffany operated on the left kidney, which was then painful upon pressure, opened the capsule freely and gave immediate relief. Patient died one month later of tuberculosis.

Case II.—J. S., æt. 65 years, Irish, occupation, carpenter. In early life had

followed the water. Was once operated upon for piles, by ligature, and cured. Temperate in habits. Pain in right loin very severe, accompanied by considerable gastric disturbance and sometimes by retraction of right testicle. Tenderness on pressure over right kidney. Sounded bladder with negative results. No blood or pus in urine. Performed nephro-lithotomy, making V-shaped incision, apex upward. Kidney appeared very large, but when pierced by needles showed no sign of stone. Punctured points bled freely. A free slit in the capsule the whole length of the kidney was then made; the bleeding ceased at once and the patient was much relieved. Symptoms simulating calculus disappeared and recovery took place.

Dr. Wm. Osler remarked that renal pain of severe character, apart from calculus, tuberculosis and cancer, is met with in at least two conditions.

The first is the so-called "renal crisis" of Dietl, in which in connection with movable kidney there are paroxysms of furious pain, sometimes associated with vomiting. They may come on quite as abruptly as the attacks of renal calculus, and recur with variable frequency. During them the kidney may be found to be swollen and tender. These symptoms of incarceration, as Dietl termed them, have been attributed to twisting of the vessels, causing strangulation and congestion of the kidney, but more likely to a kink or compression at the origin of the ureter, causing a distension of the pelvis, and in some instances a temporary hydronephrosis. The importance of a recognition of this symptom group is really very great, as cases have been mistaken for abdominal tumor, particularly when the kidney can be felt swollen and tender.

Secondly, there are instances of persistent nephralgia associated with the passage of oxalates, possibly, too, with the passage of a highly acid urine in gouty persons. In the case reported by Dr. James Chadwick (Gynæcological Society's Transactions, 1889) the patient had all the symptoms of calculus, and the diagnosis was corroborated by a number of eminent surgeons. The attacks had recurred for several years and appeared to be associated always with the presence of an extra amount of the oxalate.

The operation demonstrated that there was no stone. Possibly an explanation of the cure by incision of the capsule in some instances of severe nephralgia, in which the symptoms simulate stone, and in which, on operation, no stone has been found, may be found in the fixation of the kidney and prevention of the mobility on which Dietl's crises depend.

H. O. Reik, M. D., Secretary.
525 N. Howard Street.

The late Professor Olivieri, of Naples, left a very large estate which he had acquired from his practice. By his will he made several most munificent bequests: to the Naples Blind Asylum, $40,000; to the Pellegrini Hospital, $60,000 and his instruments; to his friend and pupil, Dr. Mottola, who attended him in his last illness, he left $20,000.

Dr. Alfred Ludlow Carroll, one of the most prominent physicians in New York, died recently. He was a member of the Carroll family, of this State.

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BALTIMORE, NOVEMBER 11, 1893.

Editorial.

THE TREATMENT OF GOUT.

The pathology of gout has been a battle-ground for contending theorists and observers. It cannot be claimed that it is thoroughly understood. As early as 1859 Garrod asserted that there is no increased formation of uric acid in the gouty, but a diminished excretion which results in an accumulation in the blood and in other fluids of the body. More recently Pfeiffer has essentially confirmed the opinions of Garrod. Another observer, Alexander Haig, has arrived at very similar conclusions, so that it is now generally conceded that there is an accumulation of uric acid in the blood, either from diminished excretion or increased formation, or both. The presence of uric acid, not precipitated, but dissolved, according to Pfeiffer, must be regarded as the irritating agent.

According to this view, an acute attack is the result of a resolution by the blood of previously-deposited uric acid, the impulse to this solution being an increased alkalescence of the blood and body juices, while the deposit is the result of diminished alkalescene. In a recent paper on the treatment of gout (*Ther. Gaz.*, Nov. 1st, 1893) Dr. Jas. Tyson reviews the views above given and comes to the conclusion that whether it be an irritant in solution or an irritating precipitate, uric acid is its cause and that whatever diminishes the amount of uric acid in the economy must tend to relieve gout. Dr. Tyson proposes two methods of diminishing uric acid: first by confining the gouty person to such food as produces a minimum uric acid; second, by administering such medicines as will promote its solution and elimination. Upon the theory that prevention is better than cure, diet must play the most important role as a preventive agent. The elimination from the food of all nitrogenous or albuminous principles whose complete combustion results in urea and incomplete combustion in uric acid must, therefore, be regarded the essential step. The list of such articles of diet is a very long one and embraces the choice articles in daily consumption in every household. The permissible foods are milk, butter, the succulent vegetables, except beans and oatmeal, and fruits, to which may be added oysters, lobsters and fish and poultry in moderation. "All butcher's meats," says Dr. Tyson, "should be strictly forbidden." The carbo-hydrates, *i. e.*, sugars and starches, and hydro-carbons, fats and oils, are likewise allowable.

"Experience," says Dr. Tyson, "shows that the stronger wines, such as Madeira

and sherry, by their continued use, are very likely to produce gout, while lighter wines—the clarets, hocks and Moselle wines—if taken in moderation, rarely produce it. After these, stout, porter and strong ales induce gout."

Of medicinal agents, there are two classes of remedies in the treatment of gout—alkalies and purgatives.

Dr. Tyson places salicylate of sodium at the top, excelling all others. "During an attack it should be given in doses as large as can be borne. As a rule, adult men easily bear 15 grains four times a day or 10 grains every two hours. Even larger doses may be given with advantage if borne by the stomach. With relief of acute symptoms the dose should be reduced." The administration of this drug by the rectum is advised when not borne by the stomach.

The alkaline carbonates are preferred after the salicylates. The lithium compounds have not proven so serviceable.

Dr. Tyson holds the alkaline mineral waters in high esteem.

The Hunyadi, Jonas, and the Saratoga and Bedford in this country, are well thought of. In this connection, the Capon, Buffalo Lithia and Berkeley waters being nearer at home, are worthy of especial mention.

The treatment of gout without colchicum is like the play of Hamlet with Hamlet omitted, hence this time-honored remedy is considered, but its place is made second to the salicylates. Among the aperients, magnesium sulphate is a favorite with Dr. Tyson. Colchicum has long been used for this purpose and it will be difficult to destroy this idol in the minds of the laity and general practitioner. Among the general principles here stated one cannot run aground in the management of gout. He will meet with most success who can enforce a strict dietary upon the consideration of his patient.

A NEW LOCAL MEDICAL SOCIETY.

The faculty, associates, alumni and students of the Medical Department of the University of Maryland have organized a medical society in connection with the work of this school. The Society will hold monthly meetings in the University building, at which meetings papers will be read, cases related and general discussions will ensue. It is believed that this work will bring teacher and student into closer relations and will encourage the habit of more careful observation and study in the student. It can hardly fail to arouse an interest in this character of medical work among young men who are entering upon a medical career, which purpose should commend it to encouragement and development.

The sooner the young practitioner of medicine is taught to regard with favor the work of the medical society the better will it be for the profession and for the society.

The organization of the medical profession is the sure cure for ignorance, empiricism and quackery in medical work. When medical men come together to exchange opinions and experiences, the habit of careful and honest work is fostered. Men do not conceal their light under a bushel by such methods of work. It is purified and made useful by the sunshine of discussion and criticism.

SIR ANDREW CLARK.

The death of this noted English physician at the age of 67 years has been mourned by the profession of Great Britain in a way seldom witnessed in any country. The high esteem and affectionate regard in which Sir Andrew Clark was held were due not so much to his rare talents and professional attainments as to his upright manly character and great professional worth. His contributions to medical science were numerous and valuable and were welcomed in every land, but his influence in his profession as Fellow and in later years as President of the Royal College of Physicians was as wide-reaching as it was beneficial in its results upon the status of the profession in England.

Beginning life with a most careful collegiate and medical training, Sir Andrew Clark may be said to have worked up to the high position he reached under difficulties which would have retarded the progress of many less ambitious men. He was handicapped with poor health in his early career and only succeeded in his laborious work by husbanding his resources and persevering in his efforts. Honors came rapidly to him because merited by conscientious work. He literally won his position by his energy, talents and professional attainments. No doubt his career was brought to an early close by the constant labor and press of work extending through some forty-five years of professional activity. As physician to Mr. Gladstone he had guided this remarkable man through the storms of advanced years and it is a somewhat singular circumstance that his own robustness was far inferior to the great Premier.

OHIO DOCTORS IN POLITICS.

The medical profession of Ohio has a rare grievance against the law-makers of that State. From year to year efforts have been made by the profession to induce the Legislature to create a board of medical examiners to regulate the practice of medicine in Ohio. The petitions offered from time to time have been turned down at the instigation of charlatans and bribed newspapers. During the recent election in that State the profession, led by the public spirit and enthusiasm of the *Lancet-Clinic*, determined that it would secure the election of candidates for the Legislature pledged to support a bill creating a board of Medical examiners. For this purpose a committee of the Cincinnati Academy of Medicine was appointed. This committee corresponded with or interviewed all the Legislative candidates in Hamilton County, and obtained a written pledge to introduce and support such a bill as may be approved by the Cincinnati Academy of Medicine from enough candidates to constitute a strong ticket. These candidates were selected without regard to political parties.

In the recent election the candidates recommended by the Academy of Medicine received 3,586 votes more than their opponents, who were not pledged to support a non-political measure. These results are highly encouraging and show the good work of organization and the influence the medical profession can exert when it determines to effect a purpose. The *Lancet-Clinic* says: "We are greatly encouraged, and urge more strongly that ever that we hold to and keep up our good work as an organization to effect legislation in favor of hon-

orable medicine. It is very rare that a general election is so one-sided in its partisan results as this one was, so that ordinarily our influenced vote of 3,586 would have turned the political scales of Hamilton County."

Many of our readers will recall the efforts made in this State to secure the passage of a law to regulate the practice of medicine in Maryland and the final triumph after years of defeats. Such results are accomplished by persistent effort and we have no doubt the profession of Ohio will ultimately win in a fight which it seems to be urging with persistency and courage.

Reviews, Books and Pamphlets

System of Diseases of the Ear, Nose and Throat. Edited by CHAS. H. BURNETT, A. M., M. D. Philadelphia: J. B. Lippincott & Co.

Volume I of this excellent work reached us in June last and was sent to the reviewer. The book was accidentally mislaid and hence the tardiness of this notice. For the book much can be said in praise, very little in the way of adverse criticism. The papers comprised in it are written by ear, throat and nose specialists in America, England and Canada. Throughout there is a notable absence of dogmatism. Each author seemingly desires to present his theme as revealed to him by his personal observation, saying what he thinks, why he thinks so, and letting the reader judge for himself. The chapter on inflammatory diseases of the external ear, by Dr. Barclay, of St. Louis, is one of the most interesting in the book. He discusses at some length otitis externa dissecans—the dissecting tympano-mastoid, tympano-temporal, tympano cervical abscesses of other writers. Worthy of mention, too, are his descriptions of diphtheritic otitis externa, and the method of determining whether an inflammation of the external ear is primary or secondary to some middle ear trouble—sometimes a very puzzling question. We may have overlooked it, but we failed to find in either text or index anything about the very common trouble, impacted cerumen.

The paper on acute otitis media and subacute aural catarrh by Dr. Bacon, of New York, and that on chronic purulent otitis media by the editor, are complete and most instructive. Dr. Bacon's remarks on ear hygiene, in connection with subacute aural catarrh, are specially important.

The surgical removal of the ossicles for various reasons is discussed by the editor, Dr. Sexton, of New York, and Dr. Jack, of Boston. A number of illustrative cases are given.

The text is well illustrated. The book is calculated to meet the wants of those desirous of studying otology thoroughly; but for the student or general practitioner it seems, to us, too complete.

Chemistry and Physics. By Joseph Struthers and D. W. Ward, Ph. B., Columbia College School of Mines, N. Y., and Chas. H. Willmarth, M. S., New York. $1.00. (The Student's Quiz Series.) Philadelphia: Lea Brothers & Co.

The Principles and Practice of Surgery. By John Ashhurst, Jr., M.D., Barton Professor of Surgery and Clinical Surgery in the University of Pennsyl-

vania; Surgeon to the Pennsylvania Hospital, Philadelphia. New (6th) edition, enlarged and thoroughly revised. In one octavo volume of 1161 pages, with 656 engravings and a colored plate. Cloth, $6; leather, $7. Philadelphia: Lea Brothers & Co., 1893.

A Hand-Book of Ophthalmic Science and Practice. By Henry E. Juler, F.R.C.S., Ophthalmic Surgeon to St. Mary's Hospital, Surgeon to the Royal Westminister Ophthalmic Hospital, London. New (second) edition, revised and enlarged. In one handsome octavo volume of 562 pages, with 201 engravings, 17 colored plates, test-types and color-blindness test. Cloth, $5.50; leather, $6.50, Philadelphia: Lea Brothers & Co., 1893.

A Text-Book of Ophthalmology. By Wm. F. Norris, M. D., Professor of Ophthalmology in the University of Pennsylvania, and Charles A. Oliver, M.D., Surgeon to Wills Eye Hospital, Philadelphia. In one very handsome octavo volume of 641 pages, with 357 engravings and 5 colored plates; cloth, $5; leather, $6. Philadelphia: Lea Brothers & Co. 1893.

Hernia; Its Palliative and Radical Treatment in Adults, Children and Infants. By Thomas H. Manley, A. M., M. D. Published by the Medical Press Co., Philadelphia, 1893. Price $3.

This is a concise and descriptive treatise of hernia in its various forms and conditions, giving the methods of palliative and radical treatment resorted to by different operators, with their results. To the surgeon, it is a valuable compend; to the general practitioner and student it will give very useful and necessasy imformation about an infirmity that is so general and prevalent. The work shows a very deep thought and theory of the subject and is well worth the price asked for it.

Clinical Gynæcology. By Thomas Moore Madden, M. D., F. R. C. S., Ed., Obstetric Physician and Gynæcologist, Mater Misericordiæ Hospital, Dublin, etc. A Hand-book of Diseases peculiar to woman, with 259 illustrations; cloth, $4. Philadelphia: J. B. Lippincott Co. 1893.

A System of Genito-Urinary Diseases, Syphilology and Dermatology. By various authors. Edited by Prince A. Morrow, A. M., M. D., Clinical Professor of Genito-Urinary Diseases; formerly Lecturer on Dermatology in the University of the City of New York; Surgeon to Charity Hospital, etc. Complete in three volumes, with illustrations. Vol. II, Syphilology. Price per volume (by subscription only), cloth, $6.50; Sheep, 7.50; Half Morocco, $8.00. New York: D. Appleton & Co. 1893.

A Text-Book of Medical Chemistry. By R. A. Witthaus, A. M., M. D., Professor of Chemistry and Physics in the University of the City of New York; Professor of Toxicology in the University of Vermont, etc. Fourth Edition, octavo, 557 pages and 62 wood-cuts. Muslin, price $3.75. New York: William Wood & Co. 1893.

A Treatise on the Science and Practice of Midwifery. By W. S. Playfair, M. D., F. R. C. P., Professor of Obstetric Medicine in King's College, London; Examiner in Midwifery to the Universities of Cambridge and London, and the Royal College of Phy-

sicians. Sixth American from the eighth English edition. Edited, with additions, by Robert P. Harris, M. D. In one octavo volume of 697 pages, with 217 engravings and 5 plates. Cloth, $4.00; leather, $5.00. Philadelphia: Lea Brothers & Co. 1893.

A Practical Treatise on Diseases of the Skin. For the use of Students and Practitioners. By J. Nevins Hyde, A. M., M. D., Professor of Dermatological and Venereal Diseases in Rush Medical College, Chicago, New (3rd) edition. In one octavo volume of 802 pages, with 9 plates, of which 3 are colored, and 108 engravings. Cloth, $5; leather, $6. Philadelphia: Lea Brothers & Co., 1893.

Medical Progress.

HOW VALUE OF PROFESSIONAL SERVICES MAY BE PROVED.

In a suit to recover the value of professional services, witnesses of proper knowledge and experience may be called to give their opinions under oath as to the value of such services, says the Supreme Court of Colorado in the case of Bourke vs. Whiting, decided Oct. 2, 1893. But such opinions are not conclusive upon the jury; nor is it absolutely essential that expert evidence should be produced in such cases. The jurors have the right, when the nature and kind of services performed are shown in evidence, together with the time and circumstances of performance, to exercise their own judgment in determining the value of such services; and, if parties submit such an issue to the jury without expert testimony, they will not afterwards be heard in complaint.—*Jour. Amer. Med. Asso.*

CATS AND DIPHTHERIA.

Dr. Edmund Gwynn, medical officer of health for Hampstead, has forwarded us the following case, which may be of interest at the present time, when diphtheria in London is on the increase, as showing once more that the disease may sometimes be traced to domestic pets: In February last a cat in a tenement house situated in Fleet Road was noticed to be very ill and suffering from a bad swollen throat. On February 24th a child aged 5 years, who had been nursing the cat, was sent into the North-Western Hospital suffering from diphtheria. The cat was subsequently sent away for treatment, but returned to the premises on July 22nd, enticed back by the children of the house, with whom it was a great favorite; it was still in a bad state of health and suffering from an unhealed abscess in the vicinity of the throat. On July 26th two other children were found to be affected with sore throat, and one was removed to the hospital, suffering from diphtheria, July 31st. The father of the children, believing the cat to be the cause of the infection, destroyed and buried it, much to the indignation of the landlady—so that no opportunity was afforded of examining the animal.—*Brit. Med. Jour.*

THE INFLUENCE OF SURGERY ON MODERN OBSTETRICS.

A paper on this subject appears in the September number of the *Journal of Surgery, Gynæcology and Obstetrics,* by Dr. Thomas Opie, of Baltimore. He is of the opinion that from the earliest times

there has always been a close relation between midwifery and surgery. The department of midwifery was then entirely in the hands of women, and it was only when the lying-in woman was in a desperate condition that male assistance, generally of a more or less directly surgical nature, was called in. The invention of the midwifery forceps in the seventeenth century marked an epoch in the history of obstetrics, and at the same time enormously increased the number of cases in which the use of instruments—that is to say, assistance of a surgical nature—was indicated. The field of obstetric surgery has similarly been widened in our own time by the success of the modern Cæsarean section and of modern symphysiotomy, a success largely due to strict adherence to antiseptic principles. In this connection we may recall the testimony of the late Dr. Matthews Duncan, who dedicated one of his books to Sir Joseph Lister because by his work on antiseptics he had "done more for lying-in women than any obstetrician." Dr. Opie recognizes three periods in tracing the relation between obstetrics and surgery. The first was the destructive epoch, when craniotomy was the chief operation for which instrumental assistance was employed; the second was the reactionary period, when the pendulum swung too far in the other direction and obstetric surgery was almost obsolete; and the third period was marked by the introduction of the forceps. We may, perhaps, be allowed to add a fourth period, which may be called "the antiseptic period," being characterised, not only by the greatly increased success of the old operations when performed in accordance with antiseptic principles, but also by the increased safety with which a woman may pass through a normal labor if those principles are faithfully and intelligently adhered to. Just as the surgeon has to consider and provide for the absolute cleanliness of himself, his patient, his instruments, and his assistants, so in a case of labor, as Dr. Opie very rightly insists, it ought to be the first practical consideration to secure the absolute cleanliness of all those who are concerned in the case, as well as of all the instruments and appliances. The need for asepsis concerns the monthly nurse nearly, if not quite, as much as the obstetrician. We observe one reason here given for the fact that so many nurses fail in their appreciation of the importance of antisepsis which is often lost sight of. It is that it often happens that a particular nurse works with many practitioners whose methods may vary widely. Some—we trust a vanishing minority—ignore the use of antiseptics altogether; some, again, use one antiseptic, others another; some use antiseptic douches after delivery, while others do not. It is not to be wondered at that an imperfectly educated woman under these circumstances should at times be led to conclude that the whole business is only so much fuss and worry, and may be safely disregarded in the spirit, if not in the letter. Much of Dr. Opie's paper is taken up with the precautions to be taken and rules to be observed in the application of the forceps, and especially he gives a note of warning against the use of the forceps when the cervix is not fully or at least sufficiently dilated—a fertile source of serious danger both immediately, as well as during

the lying-in period and afterwards. As Dr. Opie says, "it is a great gift in an obstetrician to be able to wait and do nothing. The obstetrician who is inappreciative of nature's power and ingenuity, and will not give her time in labor, has great need for the surgeon and the undertaker."

HERNIA OF THE LIVER.

Professor Kusmin records a curious case of hernia of a part of the left lobe of the liver. The patient, a woman aged twenty-eight, by occupation a cook, had suffered for a year from a painful swelling between the umbilicus and the xyphoid cartilage. On account of her stoutness, the patient, though she wore no corset, had been in the habit of tying her clothes very tightly at the waist. The sac was opened, and the ensnared portion of liver was freed from constriction and returned into the abdomen. The patient made a rapid recovery and seven months later had had no return of her complaint.—*Lancet.*

EFFECT OF AFTER-PREGNANCY ON DAMAGES RECOVERABLE FOR PERSONAL INJURY.

When a married woman substains a personal injury, and her physician does not caution her to avoid pregnancy, and there is no evidence that her injury was such that it was not prudent for him to do so, her pregnancy occurring several weeks after the accident, it is not necessarily, and as a matter of law, sufficient to justify a reduction of damages. So holds the Supreme Court of Wisconsin in the case of Sallady *vs.* town of Dodgeville (55 N. W. Reporter, 696). If the after-pregnancy may have prolonged the injury or delayed her recovery, the damages she would otherwise be entitled to recover should not be reduced because of such pregnancy. Her duty after the accident would be to take reasonable care of herself, and to advoid, so far as reasonably possible, doing anything which would tend to increase, prolong, or render permanent her injuries, sufferings, or disability. The mere doing of an act which would prevent or retard her recovery would not of itself be a groud for reduction of damages. To have that effect it must be a negligent act, and whether an act is or is not negligent is a question for the jury, and not of law for the court. So, in the case under consideration, the measure of duty, the court said, was ordinary care and diligence in the adoption of such measures of care or prevention, as the case required and were within her knowledge or power.—*Med. News.*

ANOTHER LIBEL SUIT.

Dr. William R. Amick, the consumption specialist, has sued Dr. J. C. Culberston, editor of the *Lancet-Clinic*, for $50,000 damages on account of another attack recently made in that publication.

In the issue of October 28th the following was used: "The Amick cure people are not the only quacks in this city and State."

In his petition Dr. Amick characterizes the reference to him as a "quack" as a malicious and wilful libel, and tending to dishonor him in his profession by giving out the impression that he is a fraudulent, ignorant and knavish practitioner.

A similar suit, it will be remembered, was filed when the *Lancet-Clinic* made the first assaults on Dr. Amick.

The above is from the Cincinnati *Post* of November 6.

The filing of suits seems to be a branch specialty with Dr. Amick, none of which seem to have been successfully prosecuted beyond the filing. The filer of these suits is a veritable tenderfoot among his kind, and his extreme sensitiveness is measured to the people by the good round amounts sued for.

We hope these suits will be pressed to a speedy issue. This is particularly desired in order that the doctor may have an opportunity to show to a court and the people the standing he has in the medical profession in this city, while the *Lancet Clinic* will not be slow in circulating the word in medical professional circles.

If we are rightly informed, and we think we are, the doctor had his professional ties loosened from the Cincinnati College of Medicine and Surgery, by the one, two, three, bounce process, for engaging in the practice of quackery. We think we remember of a dissolution of his membership ties in the Cincinnati Medical Society in the same way and for similar reasons. If the doctor has been reinstated in any of his relations with reputable practitioners of medicine in this or any other region, we have failed to hear of it. Whenever the suits against the faculty of the Medical College of Ohio, the one against Dr. J. M. French and the one against the editor of the *Lancet-Clinic* are called, the doctor may rest assured that the defendants will be there, and that he will be afforded an abundant opportunity to prove that he s not a quack.—*Cin. Lancet-Clinic.*

THE VALUE OF CREOSOTE IN GASTRIC FERMENTATION.

Creosote has been so largely used within the last few years in the treatment of bronchial or general pulmonary disease that many of us have forgotten the valuable results to be obtained by its employment in the treatment of gastro-intestinal troubles associated with fermentation. As is well known, the name of the substance is derived from the fact that it was found to prevent decomposition of nitrogenous matter, and that it therefore acted as a distinct antiseptic. There are two cases of indigestion or disorder in the alimentary canal in which creosote is of great value. Aside from those instances of persistent vomiting, where by its local action it often renders us great service, it is also useful in those cases of fermentation or chronic indigestion in which there are formed large quantities of flatus some time after eating. Whether the distention is caused by the fermentation of starches or the decomposition of nitrogenous materials, a minim or two of creosote half an hour or so after eating, or immediately after eating, will often help such cases. Another instance in which creosote is of value is in a case of severe acute gastro-intestinal fermentation, which is often manifested, in the more severe cases, by an actual attack of cholera morbus. The administration of creosote in such an instance not only tends to prevent the vomiting, but to inhibit the production of poisonous products which are developing from the bad food that the patient has been unfortunate enough to take. Here, again, the dose of from 1 to 3 minims of creosote, well diluted, proves of value. In those instances in which the vomiting

is too intense to permit the swallowing of much liquid, it may be administered in the dose of from ½ to 1 minim in a tablespoonful of water, milk or brandy, a few drops of this mixture being given at a time. Notwithstanding the laudatory statements which have been made as to the value of thymol, naphthaline, and other gastro-intestinal antiseptics, we believe that creosote is the best one which we can employ, and we doubt, if it is administered carefully, that it is as apt to produce disturbance of the digestion by irritation of the mucous membrane as some of the more highly praised and more expensive remedies. It is hardly necessary to add that it is important to use the beechwood creosote and not that derived from the mineral kingdom.—*Ther. Gaz.*, Nov. 1, 1893.

THE USE OF NITRO-GLYCERIN IN ARTERIO-SCLEROSIS.

Dr. T. G. Ashton, of Philadelphia, says in *Ther. Gaz.*: "The chief symptoms of arterio-sclerosis are due to the malnutrition of various organs resulting from a lessened blood-supply; nitro-glycerin relieves these symptoms by increasing the blood-supply of any given tissue. The cardiac hypertrophy, however, so common an attendant upon this disease, is caused by increased peripheral resistance. By lowering the blood-pressure and, according to Bartholow, by removing the inhibition exercised by the pneumogastric nerve, thereby lessening the work of the heart, nitro-glycerin results in relief of this condition. The advantages from the use of the drug in attacks of angina pectoris are too well known to require discussion.

Because nitro-glycerin lessens arterial tension and thereby diminishes the amount of urine voided and lessens the output of albumin, and because it increases the blood supply to the kidneys, therefore improving their nutrition, and prevent further degenerative processes, is its exhibition advantageous in the renal changes accompanying arterio-sclerosis.

Nitro glycerin is best administered in the form of a centesimal solution, or as tablet triturates, each containing 1-100 grain of the pure drug.

Inasmuch as the susceptibility to the action of the drug varies very greatly, the dose cannot be stated in advance. It is therefore advisable to begin with a dose of 1-100 grain, watching its effects and increase it until the physiological effects of the drug become manifest. In some individuals small doses will continue to maintain the physiological effect of the drug, while in others, as in a case some time since reported by Dr. D. D. Stewart, of Philadelphia, a remarkable tolerance, even to massive doses, becomes established. According to my own experience, those cases respond best to the use of the drug in which small doses continue to maintain its physiological manifestations.

The effects produced by nitro glycerin upon the pulse vary somewhat, though not materially, in duration in different individuals. In one of my cases the effects of a dose just sufficient to produce the physiological actions did not disappear from the sphymographic tracing for nearly three-quarters of an hour. According to Murrell, however, whose observations upon the subject have been made with great accuracy and have come to be regarded as authoritative, the tracing resumes the normal in less than half an hour. As the effect of the drug is but transient, therefore, the interval

between the doses should not exceed two or three hours.

Nitro-glycerin tends to arrest the oxygen-carrying function of the red blood-corpuscle, and it is therefore important not to give it in doses larger than necessary to produce the desired effects, and during long-continued courses of the drug to interpose frequent periods of abstinence from its use.

Arterio-sclerosis is a progressive disease, and it is not claimed, therefore, that nitro-glycerin will effect a permanent cure. It is claimed for the drug, however, that it will retard the progress of the affection and alleviate many of its most distressing and serious manifestations.

A NEW TREATMENT OF MAMMARY ABSCESS.

Tweedy (*Medical Press and Circular*, July, 1893) adopts Weber's method of treating mammary abscess.

An early and free incision is made in the breast, radiating from the nipple, and situated at the most dependent part of the abscess.

The finger is then inserted into the wound and the gland structure broken down. This manipulation, it is stated, will have no bad effect on the healthy tissue.

By this process several new cavities will be found, and these, in turn, are to be opened by an incision similar to the first, and the whole thoroughly douched with some antiseptic solution.

The membrane lining the several cavities is to be curetted, and the *debris* removed by a second douching.

Strips of gauze sufficient to fill every interstice of the abscess are to be steeped in a one per cent. solution of carbolic acid, and inserted by means of a long sinus forceps and probe. A large, flat sponge is then placed on the breast and tightly bandaged thereto for twenty-four hours. After this period the dressings are removed, and without further irrigation the cavities are again packed, the sponge and bandage being reapplied as before.

On the third day the process is repeated.

In the fourth dressing the gauze packing is dispensed with and the incisions are drawn together and dressed antiseptically; the sponge and bandage are reapplied.

This last process is repeated every twenty-four hours until healing is complete; this usually takes place about the tenth day. In one of the author's cases the whole process was accomplished without the aid of anæsthesia. In only one of his cases was it necessary to make a second incision. The incisions are never longer than is necessary to admit a finger.

Iodoform gauze should be used for packing the wounds.

The author only having treated five cases, cannot say definitely what portion of the above treatment is essential, but he is strongly inclined to the opinion that curetting can be safely dispensed with.—*Ther. Gaz.*

Medical Items.

Dr. John F. Wynn, editor of *Practice*, has been elected Professor of Diseases of the Nervous System in the College of Physicians and Surgeons of Richmond, Va.

India proposes to have a medical congress.

Professor Potain has been elected successor to the late Professor Charcot, in the Academie des Sciences.

There were treated at the World's Fair Emergency Hospital, 18,500 cases, and there were twenty-three deaths at the institution.

Washington, which has already four medical colleges, is now favored with a fifth, viz., the National Homœopathic Medical College.

The *London Lancet* was recently sued by Keeley, of the "gold cure" notoriety, for libel. The suit was recently dismissed and Keeley is obliged to pay the cost.

The Philadelphia County Medical Society has appealed to the Board of Health of Philadelphia to place tuberculosis upon the list of contagious diseases to be reported to the Board.

M. Pasteur, on the occasion of his jubilee, will be presented by the Municipal Council of Paris with an album containing an address, the ornamental part of which is being executed by Ernest Guillot.

The American Public Health Association has elected lhe following officers: President, Dr. E. P. La Chapelle. of Montreal; First Vice-President, Dr. Manuel Carmona y Valle, of City of Mexico; Second Vice-President, Dr. J. N. McCormack, of Bowling Green, Ky.; Treasurer, Dr. Henry D. Holton, of Brattleboro, Vt.; Permanent Secretary, Dr. Irving A. Watson, of Concord, N. H. Place of next meeting, Montreal, Canada, October, 1894.

At a meeting held for the purpose at the University of Maryland, Baltimore, the "Medical Society of the University of Maryland" was organized with the following officers: President, Dr. J. J. Chisolm; Vice-President, Dr. C. W. Mitchell; Secretary, Dr. W. B. Canfield; Executive Committee, Drs. J. E. Michael, W. B. Platt and J. M. Hundley. The society will be composed of the faculty, adjunct faculty, members of the teaching and hospital staffs and graduates of the University, and will meet on the first Tuesday of each month.

At the recent meeting of the Tri-State Medical Society, held in Chattanooga, Tenn., the following officers were elected by ballot: President, J. B. S. Holmes, M. D., Atlanta, Ga. Vice-Presidents: James A. Goggans, M. D., Alexander City, Ala.; Dan. H. Howell, M. D,, Atlanta, Ga.; T. Hilliard Wood, M. D., Nashville, Tenn. Councillors: W. E. B. Davis, M. D., Alabama; G. W. Mills, M. D., Georgia; J. B. Murfree, M. D., Tennessee. Secretary, Frank Trester Smith, M.D., Chattanooga,Tenn. Treasurer, W. C. Townes, M. D., Chattanooga, Tenn. Recorder: W. L. Gahagan, M. D., Chattanooga, Tenn. The next meeting will be held in Atlanta, on the second Tuesday in October, 1894, and the proposition to change the name to the South-Eastern Medical Society will be considered. This will embrace the territory east of the Mississippi and south of the Ohio.

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THE BACILLUS OF RABBIT SEPTICÆMIA OBTAINED FROM THE MEDULLA OBLONGATA OF A SUPPOSED RABID DOG. THE BACILLI COLI COMMUNIS, CAUSING HUMAN SEPTICÆMIA, IN PISTOL-SHOT WOUND OF THE LIVER.*

BY N. G. KEIRLE, A. M., M. D.,

Professor of Pathology and Medical Jurisprudence in the College of Physicians and Surgeons, Baltimore; Medical Examiner for Baltimore City.

In the course of an investigation into the subject of rabies, undertaken last November, it became necessary for the purpose of control experiments to use a number of dogs, and one object of these controls being the determination as to whether any other disease than rabies could give rise to like signs and symptoms, it was requisite to use sick dogs; therefore the dogs used had died or been killed because of suspected rabies. The bacteriological developments of dog number 17 are noteworthy. This dog was a yellow cur, weight about 20 pounds, shot and his skull crushed on the 21st of last September. He had attempted to bite a number of persons; did bite other dogs; took refuge in a stable and bit a horse.

Post-mortem examination on the 22nd of September, 1893.

Inspection.—Skull crushed and brain torn; mouth pigmented; cheeks and under surface of tongue bluish vascularity; bits of coal and splinters in mouth; right lower front incisor out.

Section.—Cervical lymph glands enlarged and blood effused into them.

Brain lacerated; skull crushed in.

Medulla oblongata under surface very vascular.

*Read at the meeting of the Clinical Society of Maryland, Nov. 3, 1893.

Larynx somewhat red; membrane of ventricle protrudes.

Œsophagus pinkish.

Stomach contains particles of hair, straw, grape-skins, feathers.

Heart: blood coagulated.

Lungs ooze a sanious serum.

Liver congested.

Spleen, reddish, firm, weight 19.2-5 grams; length 16 c. m., width at wider end 4 c. m.; at other end, 1 c. m.; thickness 5 m. m.

Cultures from medulla oblongata, spleen, lymph glands and parotid, grown in gelatin; culture from lymph gland (cervical) in bouillon, placed in thermostat.

September 24th, 4 P.M., gelatin liquified contaminatively (which the organism about to be referred to does not do).

Cultures in bouillon are very fetid, and exhibit lance-shaped cocci (bacilli); also bacilli with clear interspace and bipolar staining and curved chains of five or six; there is also a short thick bacillus in gas vacuole; this organism is present in common putrefaction. The cultures from gelatin are less gross than those from bouillon, exhibit more clearly the intermediate clear space. The odor of gelatin cultures is as fetid as the bouillon; the above applies to cultures of the cervical lymph glands of dog 17 and the heart blood of rabbit R in gelatin, below referred to (rabbit R trephined from medulla of dog 17).

This bacillus with rounded ends, bipolar staining and clear interspace, varies in size in the same media, differs in size in different organs and structures; it is the well-known bacillus of rabbit septicæmia, and further reference to its morphology and mode of growth is out of place on this occasion; lenses of good definition are indispensible because the organism is often very short, and the clear interspace very narrow; easily mistaken for juxtaposed cocci.

The ordinary carbol-fuchsin stain, if allowed to remain but a few seconds on the cover smear, gives satisfactory results.

The following are the details of the experiment. On September 22nd, 1893, three rabbits were trephined and one cubic millimeter of the medulla oblongata of this dog, rubbed up in bouillon, was introduced beneath the dura. On this same occasion three rabbits were injected in the lumbar region hypodermatically with 1 c. c. of a bouillon mixture of medulla oblongata of this same dog; these rabbits were designated by letters; R, W and X were the three rabbits trephined.

Rabbit R died on the third day, rabbit W on the second day and rabbit X on the second day.

The rabbits injected directly with the mixture of medulla oblongata in bouillon are indicated by the letters K, T, W.

Rabbit K died on the second day, T on the fourth day, and W on the second day.

Cultures made from the heart blood of all of these animals exhibited the organism described above.

Cultures from the heart blood of rabbit R, which was trephined from the medulla of dog 17, injected into rabbit Y, killed it in one day. This ends the trephining experiment.

Cultures from the heart blood of rabbits K and T (which rabbits were directly injected with the medulla oblongata of the dog) killed rabbit Y′ in one day.

This ends the experiment with the medulla.

Referring to the post-mortem examination of dog 17, it will be seen that his cervical lymph glands were enlarged and blood effused into them. Cultures from the glands give the following interesting results: One cubic centimeter of the bouillon culture injected into rabbit Z killed it on the second day; this is the first remove from the dog.

Cultures of the heart blood of rabbit Z in Dunham's fluid were injected into rabbit Z′; it died on the second day.

Rabbit T′ was identically injected and also died on the second day; these rabbits are second removes from the dog.

Guinea-pig H, injected with 1 c. c. culture of heart blood of rabbit Z in Dunham's fluid, died on the sixth day.

Guinea-pig G injected with 1 c. c. cultures of heart blood of rabbit Z in gelatin died on the sixth day. These guinea-pigs are second removes from the dog.

Mouse A injected with 5 minims of culture of heat blood of rabbit Z in Dunham's fluid; died on the third day. This mouse is the second remove from the dog. Cultures from heart blood of this mouse A in Dunham's fluid injected into rabbits S′ and L′ killed them on the third day; this is the third remove from the dog. Cultures from heart blood of guinea-pig G (above mentioned) in Dunham's fluid injected into rabbit R′ and Q′ killed them on the second day; this is the third remove from the dog.

Cultures from the heart blood of this same guinea-pig G injected into pigeon A killed it on the seventh day; this is the third remove from the dog.

Rabbit N′ was injected with the culture of heart blood of pigeon A and died on the second day; this is the fourth remove from the dog.

The experiment ceased with the fourth remove from the dog.

Another, pigeon B, was killed by an injection of the culture of heart blood, this being also the fourth remove from the dog through mouse A.

All of these animals, as well as the cultures, exhibited the organism as described above.

Two white rats, three times injected, remain immune. It is to be noted that when other animals than rabbits have been killed by cultures, other rabbits have been killed by cultures from these animals, constituting a return control experiment.

The signs and symptoms of this disease, septicæmia in the rabbit, ante-mortem and post-mortem, are markedly characteristic. The ante-mortem signs are somnolency and dyspnœa. The animal sits with its ears backward upon its body, its flanks panting laboriously, its eye-lids constantly closing.

The alvine evacuations are pultaceous.

The temperature may rise to 106 °F., which is one or two degrees above the normal maximum; this rise is very transient, rapidly falling below the normal three degrees; the minimum normal temperature in the rabbit being about 100 °F.

Usually the animals die quietly, exceptionally convulsed. A constant post-mortem characteristic is the pale, salmon-colored, bloodless (anæmic), collapsed lung. The spleen is sometimes enlarged; the liver friable; the intestine has exhibited no lesion except perhaps increased vascularity.

The site of the injection usually shows increased vascularity, exceptionally sloughing.

Special attention must be directed to the dyspnœa, which is hæmic, not pulmonary. The lungs are pallid and bloodless, or, more correctly stated, the blood is not red blood, the red blood corpuscles are not red; even when closely agminated, the color is only a faint yellow, and the single corpuscle has no color at all. Morphologically the red corpuscles are distorted, fail to maintain their sphericity, and many, like a globule of mercury, drag a tail; in addition to this poikilocytosis, there is a pseudo-nucleation caused by peripheral absence of protoplasm (hæmaglobin). This excessive liability to vacuolation of the corpuscles is general and takes place in different parts of the area of the cell. Sometimes the cell is emptied of its contents, the peripheryalone as a mere ring remaining; sometimes, as just noted, a zone between the circumference and the centre is vacuolated, leaving the centre as a seeming nucleus; the term excessive liability has been used advisedly, because cell vacuolation occurs as a post-mortem change; and as the result of reagents, especially acid stains (dyes); but this disintegration, this granular necrosis, this proneness of protoplasm to drop out, is an intra-vitam result of this organism, a pernicious anæmia.

Of great interest is the fact that this organism of rabbit septicæmia was obtained from the medulla of the dog and it is not improbable that in certain diseases of the dog in which these animals act peculiarly and are regarded as rabid that they may be suffering from the effects of this organism.

What effect the organism of rabbit septicæmia would have upon the human animal has not been ascertained.

Sternberg* found the organism in the liver of a yellow fever corpse, though this liver had been wrapped up antiseptically. I have found this organism in a liver with small abscesses, cultures from which speedily killed mice and rabbits and the cadavers quickly decomposed.

Ernst,† of Harvard, calls attention to the fact that in experimenting with rabies rabbits are apt to die of cords in a condition of early putrefaction. Whether this bacillus of rabbit sepicæmia is an organism causing early putrefaction and has its habitat ex corpore, or like the bacillus capsulatus lanceolatus, exists normally within the body and only asserts its influence under certain conditions, is still unknown.

Davaine has shown that this organism is present in putrefying ox blood, but it is not passively present; it actively causes, is the agent of, decomposition; effecting not only post-mortem, but ante-mortem destruction of the protoplasm, vitiation, ruination, of the hæmoglobin.

The following post-mortem examination develops evidence that another well known organism, the bacillus coli communis, may cause a form of septicæmia in the human being.

A woman, colored, died Oct. 30th, 1893, having received two pistol shot wounds September 29th, 1893; one entered the epigastrium, passed through the left lobe of the liver and into the lung, where it lodged. The other entered below the inferior angle of the

*Sternberg, Manual of Bacteriology. 1892, page 409.
†Ernst, Am. Journal Med. Sciences, April, 1887, page 321.

left scapula and passed into the lung; the lungs exhibit areas of traumatic consolidation. The liver had undergone fatty degeneration, the kidneys were in a condition of cloudy swelling, the gall bladder was distended and contained four ounces of yellowish earth-colored fluid, very fetid, and some soft biliary concretions; the fluid contains pus and numerous bacilli coli communis.

This organism is also found abundantly in the heart blood, in the liquor sanguinis and in the corpuscles, which are misshapen as in poikilocytosis. The leucocytes, polynuclear, are also too numerous. The condition is that of anæmia; the same organism was found in the blood during life.

Emmerich found this organism in the blood of cholera cases, both before and after death; does it cause the blood dissolution, the anæmia of this disease? Emigrating from the bowel, it has been detected in the brain; so that organisms normally present, and usually innocuous, may, under conditions not definitely formulated, produce and disseminate vicious metabolism.

In the compilation of this report, much assistance and suggestion has been afforded by Julius Friedenwald, A. B., M. D., Demonstrator of Pathology, College of Physicians and Surgeons.

In renal colic we are in favor of using atropia in connection with the morphine injection. The atropine, it is true, counteracts the effect of the morphine to a certain extent, but both are anodynes and it is much safer to use the atropia with such large doses of morphia as are usually required in such cases.—*The Kansas Med. Jour.*

DIAGNOSIS AND TREATMENT OF PUERPERAL SEPSIS.†

BY E. E. MONTGOMERY, M. D.,

Professor of Clinical Gynecology, Jefferson Medical College; Gynecologist to Jefferson and St. Joseph'sHospitals; Obstetrician to Philadelphia Hospital.

Gentlemen:—The patient I bring before you is a young colored woman 20 years of age, who was confined at the Maternity Department of the Jefferson Hospital on the 26th of September last. Her labor was normal and attended with a slight tear of the fourchette, which was shortly afterward sutured. Previous to her confinement she had been suffering from a yellow discharge. At 4 P. M., on the day of her confinement, her temperature was 101.1-5; the following morning it was 98.4-5; the second day the temperature was 98.3-5 in the morning; in the evening it was 103; on the third day, morning, 98.4-5; in the evening 104. The next two days the morning and evening temperature was higher than normal but did not rise above 101.2-5. The 3rd of October, seven days after the confinement, it again reached 104. At this time the patient was subjected to a curetting, followed by a two per cent. creolin douche. The following morning, temperature was 101, and in the evening again nearly 104. For the next seven days her temperature never was below 101, and twice reached 105. During all this time the patient had complained of no pain or distress, was always ready for food, and the greater part of the time her pulse was not high. We notice, in looking over the record, once or twice it reached 120, this only after the temperature had re-

†Clinical Lecture Delivered at the Philadelphia Hospital, October 14th, 1893.

mained high for a number of days, but there is no record of any chill. The fifteenth day after her confinement she entered this house. I made a careful examination at that time of the pelvis, found the uterus possibly a little larger than normal, and the fundus of the organ softer than usually is experienced, but there was not the slightest sign of any inflammatory condition, no fixation, no tenderness, and no enlargement of ovaries or tubes.

I bring this patient before you for the purpose of studying the condition which has given rise to such marked elevation of temperature during her puerperal convalescence. There are a number of conditions which may produce an elevation of temperature following confinement. Of course the first that would impress the attendant would be the possibility of the development of sepsis. Sepsis may have its expression in any inflammatory condition of the uterine mucous membrane, wall of the uterus, the cellular tissue, extending through the uterine mucous membrane, to that of the tubes, involving consequently the tubes, ovaries, and the enveloping cellular tissue and peritoneum. We may have a localized, or even a general, peritonitis. Then, again, sepsis may show itself in inflammatory conditions developing in the mammary gland, producing disorder of this organ. The occurrence of pregnacy does not necessarily, of course, interfere with the development of some intercurrent disease, such as typhoid fever, acute tuberculosis or malarial conditions. This temperature sheet in its beginning might lead one to suspect that the marked rise and the subsequent subsidence to normal or nearly normal, indicated the presence of a malarial poison. Later, however, we find the variations are slighter. All the conditions named will cause the marked symptom here presented, *i. e.*, high temperature. As we have already said, the presence of elevation of temperature following convalescence at once arouses the attention of the alert physician to the possibility of sepsis. He examines his patient carefully, to determine whether there is a possibility for the patient to have become infected through foci which have been overlooked. In this patient, every precaution has been exercised during her delivery to prevent the possibility of any infection occurring. She was under carefully trained nurses and continually under the watchful care of a carefully trained physician.

The external parts were thoroughly washed, and the vagina douched with creolin, as is the rule in all such cases, prior to her delivery. Subsequently the parts were thoroughly washed, the slight tear in the perineum sutured, and the patient placed in a satisfactory condition for recovery without the occurrence of infection. The same day her temperature arose to over 101. Such an elevation of temperature, however, would not be considered alarming; need not be considered as indicative of any serious trouble, as patients, not infrequently, from reflex phenomena, or reaction after labor, will have an elevation of temperature. The following day it was not so high; the third day we find her with an evening temperature of 103; in the morning it had been nearly normal. This would necessarily be a source of alarm. Occurring at this period the natural inference would be that there

was infection, and that elevation of temperature was due to the absorption of ptomaines. The patient was at once freely purged, under which her temperature subsided to 101, and again reached 104.2-5 on the eighth day. Although this patient had been given continual vaginal injections (and if I am not mistaken, intrauterine irrigation had been practised), had been carefully watched, and there was, at no time, any offensive lochia, yet the elevation of temperature led her physician to explore the cavity of the uterus and use the curette with a view of scraping away the debris and broken down tissue. The curetting had very little effect upon the subsequent progress. The temperature kept up, notwithstanding the patient was given intrauterine irrigation, frequently practised, cold sponging, quinine in moderate doses (5 grain), and she was freely purged.

Now, while the elevation of temperature, as we have said, would lead to the inference that we had to deal with a case of sepsis, yet it was the only symptom that could be so attributed. We do not have patients suffering from sepsis without some indication of local lesions. Careful search of this patient's pelvis has failed to disclose, 1st, in the intrauterine examinations any sign of a septic process. The uterus has never been tender; there has not been the slightest indication of tenderness over the abdomen. She can bear handling without any trouble; at no time has she made any complaint. She has been ready to eat and take nourishment. In addition to this she has had, the greater part of the time, a slow pulse.

In looking over the record we see that it has been as high as 120; this, however, only once, when the temperature was high. The majority of the time the pulse has been below 100. Her expression is good; she shows no special anxiety nor discomfort. There has been no derangement of the stomach, and careful pelvic examination fails to disclose any enlargement or fixation of the uterus or its appendages. Then, again, the temperature record is not that of sepsis. Usually in sepsis we will find that the patient, while the temperature is continuously above normal, has marked exacerbations, the temperature running up high, accompanied with a severe chill or frequently recurring chills. We have nothing of the kind in the history of this case.

As an indication of what I mean, I recount the history of a patient seen some years ago in consultation with a physician in a neighboring city; a woman who, in her first confinement, after an easy labor, was delivered of a child, with a slight laceration of the perineum. This was not sufficiently large to require the introduction of sutures. I saw the patient a week later, when she had a temperature of nearly 106. She had had a couple of severe rigors. I was asked whether there was any condition of the pelvic organs requiring an abdominal section. Careful examination of the appendages disclosed absence of any apparent enlargement or tenderness. The uterus was then dilated, when it was found there was considerable offensive debris within its cavity. This was carefully curetted and scraped away with the finger and curette, the uterus irrigated, and a twist of iodoform gauze

carried to the fundus of the organ in order to promote more thorough drainage. The temperature of the patient subsided, reaching normal the next day, and remained so for fifty-four hours, after which it varied from 99 to 101 for three weeks. Then her temperature again reached 106, accompanied with rigors. I again saw her and found no more indication of trouble in the pelvis than formerly, no fixation whatever of the uterus. I left her with the hope that the condition was a mere incident in her recovery, and that the elevation of temperature would subside; but in thirty-six hours I was recalled to see her, as she was still suffering from rigors and elevations of temperature. When seen in the afternoon, she had a temperature of 104, and was then in a chill. In sheer despair, to determine the condition, I opened the abdomen, found the left ovary four times its normal size, apparently œdematous; the right ovary was twice its normal size; no appearance of inflammation in the tube, no pocket of pus about the uterus, nor any enlargement of the ovary. The left ovary had a flake of lymph on its anterior surface and a similar piece of lymph was projecting from the orifice of the tube. Both ovaries were removed, the abdomen cleansed, and subsequently, on removing the ovaries, a teaspoonful of foul, stinking pus was found in the left ovary. This patient's temperature subsided, soon became normal and her subsequent convalescence was uninterrupted. Now, this was a case in which infection had extended through the uterus and tube, without setting up inflammation in the latter, and had reached the ovary, giving rise to an abscess within it. The history of high temperature, of rigors, led us realize that there must be some center from which the poison was disseminated. In this patient, however, we have had for a good part of the time an almost continuous high temperature —this in spite of sponging, in spite of agents to abate it—and not once was there a rigor, nor has there been any other symptom indicating the possibility of sepsis. The course of the temperature is not what we would suspect, excepting at its beginning, from malaria. Patients in whom malarial poisoning exists not infrequently have elevation of temperature, following confinement; elevation of temperature quite high, and accompanied by marked exacerbations. The temperature in the interval between the rigors may fall to, or even below, normal. In this patient, however, we had from the eighth up to the fifteenth day the temperature never below 101; twice, on the thirteenth and fifteenth days, it reached 105, so that we do not have the characteristic temperature sheet of malarial fever.

The history of the patient, death of her mother, brothers and sisters from pulmonary tuberculosis, with the character of the temperature, would justify the suspicion of possible tuberculosis. When we come to consider the history, however, there is nothing in it further than the elevation of temperature that would favor such a supposition. She has had no cough, no frequency of breathing, pulse has not been especially rapid, there is no tenderness over the abdomen; indeed, nothing to justify us in pronouncing it acute tuberculosis.

As we look at the temperature record, with the exception of the first two days, we will find that the mean temperature gradually reaches its maximum at the

end of the week. From this time on until the end of the second week the mean temperature was nearly the same. At the end of the third week it gradually declined, until to-day the temperature is nearly normal. We find the variations between morning and evening are from one to two degrees.

As we look at the temperature chart and notes, we find that there are recorded a number of daily evacuations from the bowel of liquid yellowish colored stools. There has been some tympanitic condition of the abdomen. The patient has presented the peculiar uncomplaining, self-satisfied condition that often characterizes typhoid fever, so that I have no hesitancy in pronouncing this a case of typhoid fever complicating the convalescence after pregnancy. It is not my purpose to occupy your time in discussion of this subject, as it can be much more profitably done by those who devote themselves more especially to its study and treatment. I do propose, however, to consider further the subject of sepsis. Sepsis usually makes its appearance the second or third day after the delivery of the patient. It may occur as late as the eighth or tenth days. In the consideration of this subject, we are no longer tied up by the former ideas regarding the pathology of puerperal fever—that it is a disease having a distinct entity of its own—but we realize that it is due to the absorption of septic matter and the development of what is commonly known as surgical fever. With this understanding of the case, we can realize that it may occur at any period during the convalescence, naturally, however, being more prone to occur in the earlier than in the later periods. It is manifested, of course, in different ways; generally by chill, elevation of temperature, more or less pain, either confined to pelvis or extending over the abdominal cavity, tympanitic abdomen, sensitiveness to pressure, and absence of offensive lochia.

The subsequent manifestations of the disease depend somewhat upon the site of its development. Thus the pain is less marked, less severe, where the endometrium and the uterine walls are the seat of the disease, than when it has extended either through the blood vessels, lymphatics, or the tubes and cellular tissue to the peritoneum. In the latter cases, of course, pain is a marked symptom. The parts are excessively tender to pressure, the patient occupies the dorsal decubitus with the limbs drawn up; the mere contact with the clothing adds to her discomfort. When the disease is uninterrupted it usually pursues a rapid course, the temperature continues high, accompanied with rigors, increase in pain, nausea, vomiting, distended abdomen, pressure against the diaphragm, interference with the heart's action and a rapidly fatal termination; or, again, the disease may become localized, forming an abscess in one or other broad ligament, or involving the tube and ovary, and consequently may rupture into the bowel, vagina or bladder, and the patient be subjected to a long period of invalidism. Or again, the disease may extend to the uterine sinuses, forming multiple abscesses in the uterine walls. In such patients the temperature may subside, and the patient apparently convalesces. Such cases, however, are usually accompanied with slight elevation of temperature, running from 99 to 101, and also accompanied with a rather

frequent and excitable pulse. A case of this kind occurred in my experience in this hospital, a number of years ago, during my early service in the institution, in which the woman had an attack of sepsis, involving, more particularly, the uterus. Under treatment this had subsided, and we supposed convalescence was established. Her temperature, however, varied between 99 and 101. Her pulse was frequent, appetite poor, and she was slow in gaining strength. After this had continued some four weeks she suddenly was taken with collapse and died in less than forty-eight hours. On opening the abdomen, it was found that the fundus of the uterus had been completely destroyed by abscess formation, leaving the organ resembling a funnel. This gangrenous detritus had escaped into the abdominal cavity, producing collapse. Cases in which the infection passes into the uterine sinuses are usually more virulent than those in which it has traveled through the uterus into the tubes. In the former, the maximum temperature is higher and the progress of the disease more rapid. Where it travels into the tubes, the discharge from the tube irritates the abdominal orifice, leading to rapid sealing up, which prevents further extension. The result is that the collection is a localized one and the inflammatory symptoms may subside, leaving the patient with a localized pus collection. Such cases, of course, afford more time for treatment. What shall be the treatment to which we subject a patient? When we consider the rapidity with which the poison may travel through the lymphatics and blood vessels to the deeper tissues, or through the uterus to the tubes, leading to destruction of their function and the consequent crippling of the life of the individual, we can realize the importance of being upon the alert and endeavoring to arrest the development of the poison as early as possible.

A Frenchman, by the name of M. Marcel Baudosier, during a recent visit to this country took occasion to take in the World's Fair, the California Athletic Club and other passing objects of interest and has come to the conclusion that "American prostitution" heads the list of American exhibits. He pronounced New York the most debauched city of the two Americas. The *Med. Record* regrets that M. Baudosier did not stop in New York long enough to see the work of its hospitals and colleges, rather than spending his time in the night displays of the Tenderloin district.

The greatest interest the State can have is found in a promotion of the healthful condition of all its citizens. This is paramount to all else, and the natural advisors in this relation are the physicians of the State.

An appropriation of $5,000 per year for the entire expenditures of the State Board of Health is only one-third or one-fourth of what is actually needed for the necessary workings of that portion of the State government machinery. Think of that small sum in comparison with the seven hundred and fifty thousand dollars annually expended for the investigation of diseases of domestic animals, of which no one complains.—*Cincinnati Lancet-Clinic.*

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BALTIMORE, NOVEMBER 18, 1893.

Editorial.

THE HARVEIAN ORATION.

The Harveian oration, delivered at the Royal College of Physicians, London, on October 18th, was founded and endowed by Harvey in commemoration of all benefactors of the college, and as "an exhortation to others to follow their example and to search out the secrets of nature by way of experiment, and for the honor of the profession to live in mutual love and affection." Dr. Pye-Smith was the orator this year and his oration was devoted largely to a discussion of Harvey's intellectual work. He held that Harvey contributed—or would have done so, had not his manuscripts been destroyed when with the king at Oxford—a systematic study of morbid anatomy. Harvey called attention in one of his papers to the benefit that would ensue from the regular observation of structural changes produced by disease, a novel idea at that time. The systematic study of organs after death was not practised until over one hundred and fifty years after Harvey's death. He had, however, made and recorded many autopsies and had recommended the study of morbid anatomy. Dr. Pye-Smith claimed that had Harvey's reports been preserved, the study of morbid anatomy would no doubt have begun a century and a half earlier.

GLANDERS IN MAN.

Whilst glanders in the horse is, comparatively speaking, an uncommon disease, it occurs with sufficient frequency to suggest the importance of its suppression, not only as a matter of domestic economy, but with a view of preventing its occurrence in the human family.

According to the *British Medical Journal,* this disease has in London about 2,000 equine victims annually. On October 7th, William Wallace, a horse-keeper in the employ of the London Road Car Company, was bitten on the fourth finger by a horse which was suffering from glanders. Wallace died on October 28th from the effects of the disease, in this manner contracted from the horse. The communicability of the disease was clearly established and serves as a warning that human life is not always safe in the presence of this loathsome affection.

The duty of suppressing glanders as a matter of animal economy has been recognized in this State, but we doubt whether the presence of the disease is always recognized or as frequently reported as its nature demands.

According to experts, glanders is com-

paratively easy of extirpation. Sterilized culture of the gladers bacillus subcutaneously injected into healthy animals produces a distinctive reaction in animals affected with occult glanders. Veterinarians claim that this product will determine the existence of the disease in the horse and thus enable horse-owners to know whether an animal should be killed or not.

Medical Progress.

A CASE OF SUPRAPUBIC CYSTOTOMY.

Keen (*Journal of Surgery, Gynœcology and Obstetrics,* July, 1893) reports the case of a man, aged 75, who for several years had passed small calculi with the urine at frequent intervals and in considerable quantity. For days before the operation he had retention. Examination by the rectum showed a very large prostate. In operating upon the bladder air was injected into this viscus until it formed a distinctly elastic tumor in the middle line. At its upper border was another tumor one inch and a half in diameter, which was found later to be a distended pouch. As soon as the bladder was opened the air escaped. The edges of the bladder wound were seized with hæmostatic forceps, and the calculi were removed with the finger and a scoop. They were counted after the operation and found to be four hundred and ninety-five. The entire weight was three hundred and eighty-six grains.

The rectal bag was not used during the operation, for it was found that the bladder could be lifted up more with the air alone than with the rectal bag. The use of air has the advantage that there is far less danger of rupture of the bladder, because the air is much more compressible than water and it lifts the bladder better. Another advantage of the air is that it gives a dry wound instead of one filled with blood and stained fluid.—*Ther. Gaz.*

WHAT SHALL WE DO WITH THE CRANKS?

Dr. George H. Rohé, M. D., of this city, writes in *The Medical Fortnightly:*

The crank refuses to be judged by the world's standards. He judges the world by his own standards. He may apparently accept the general judgment as his rule of action when he cannot help himself, but it is always under an expressed or implied protest. He knows (in his own mind) that he is right and the world is wrong. So long as he fears the public may not take his view of things he usually does not commit any act that might bring him within the pale of the law; but when his egotism or his delusions of injustice so dominate him that he regards himself as an individual of superior powers, or a much wronged man (both delusions often exist) he defies public opinion, custom, law, and becomes a dangerous and irresponsible lunatic.

So long as the crank seeks the aid of others to help him in his schemes, he is usually innocent of harm and may be the instrument of good. When he feels himself powerful enough to right things by himself, he becomes a source of danger to the community.

The crank is an egotist. He is born so. His egotism is manifested in various ways in his youth; he is not like

other young people; he is singular, or peculiar. He is usually unsocial, because he finds few who view things as he does, and hence finds it more agreeable to dwell within himself than to associate with others.

The crank is never cured of his crankiness. Once a crank, he is always a crank. He may remain an innocent crank all his life, but he is always potential for mischief. He sees visions and hears voices. He tastes or smells poison in his food and drink. He is persecuted unjustly. He is not accorded that recognition which is his due. So long as his suspicions are not concentrated upon individuals, he feels or complains that he is ill-treated. When he fixes the responsibility upon any one he takes measures which, in his opinion, are necessary to protect himself. These measures vary with the crank's opinion of his powers. If he is afraid of consequences, as he sometimes is, he complains to the public, or invokes the law against his persecutor. If he no longer recognizes the stronger power of the law he takes the law into his own hands and slays his persecutor. His overt act is usually the outcome of an egotism that overtowers his logical faculties. It may be, however, the irresistible act of a sufferer driven to frenzy and desperation by his hallucinations and delusions.

The crank rarely commits suicide. Not, indeed, because he is afraid, but because he can see no reason for his own killing, but abundant reasons for the killing of his persecutor. For a similar reason he can see no justice in his punishment. Having acted in self-defence, as he imagines, or in defence of some principle, society and the law should, and in his opinion will, justify his action.

What shall be done with the crank? That depends. So long as he commits, or threatens to commit, no act against the peace and well-being of society, he cannot well be restrained of his liberty of action; his liberty of thought cannot under any circumstances be taken from him. If he threatens injury to another, shall he be restrained? Undoubtedly. Not placed under bonds to keep the peace, for that would not avail; not confined in jail or penitentiary, for that would label him criminal, recognize his responsibility, punish him in his opinion unjustly, and give him reasons to carry the threat into execution when liberated.

Supposing, however, that the crank should kill his child, or his friend, or a public official, or under the domination of his delusions sets fire to his imagined persecutor's house or barn; shall he be hanged or sent to prison? By no means. For the crank is insane, and the law cannot hold him responsible for his acts any more than it can hold him to account for his morbid thought. Both are consequences of an abnormal brain which he brought into the world with him and for which not he, but his ancestors, or his pre-natal environment, are accountable.

But, if society may not punish the crank, it has both a right and a duty to protect its members against his dangerous ebullitions. The mischievous crank should be deprived of his liberty, under due forms of law, of course, and placed in seclusion for life. That, it seems to me, is the only logical course. The criminal dreads the law and may be de-

terred from committing a crime, by fear of the consequences. The dangerous crank dreads no consequences and fears no law.

The proper place for the crank is the insane hospital, if he has trespassed against the life or property of his neighbor; still he is no criminal, and he belongs not to the gallows, the jail, or the penitentiary, but to the insane hospital.

But his detention must be permanent. He never had mental health; he never will have it. He is a defective individual, and by the laws of civilization, society is charged with his maintenance without prejudice to himself, and to its own safety.

THE EMERGENCY TREATMENT OF A TOOTHACHE.

Dr. John E. Weaver, of Rochester, N. Y., says in *Med. Rec.:*

Toothache is a little thing in the books, but many physicians would rather meet a burglar on a dark night than a call to cure a bad toothache of several days' continuance; a hypodermic of morphine only postpones the evil day, and usually the patient is respectfully referred to the dentist. The tooth should not be extracted while the jaw and gums are inflamed and the latter swollen, and it is the physician's duty to treat the case until the above conditions are removed. Always keep a small phial containing the following mixture: Chloroform, gtt. x.; glycerine, gtt. x.; sat. sol. ac. carbol., gtt. x.; morphine, gr. j., with a small wad of absorbent cotton. If the offending tooth has a cavity or decayed surface, saturate a small pellet of cotton with the above mixture and put into the cavity, or against the decayed surface as the case may be—never pack the cotton in, or the more is the trouble—but have the pellet small enough to enter without crowding. When the gums are swollen and tender paint two or three times, two minutes apart, with a four per cent. solution of cocaine. This time of year your patient may have been eating a good deal of fruit. Tongue and mucous membrane of the mouth are pale, sour stomach, and next day the toothache will return. Give ten grains of sub-carbonate of bismuth and ten grains of phenacetin at once and a similar dose before each of the three following meals, with a laxative if needed, and stop all fruit for a few days, and it will not return. The same powder every two hours, and cessation of fruit eating, will stop the persistent, tormenting neuralgias so prevalent at this season.

VENESECTION IN THE TREATMENT OF ENGORGEMENTS AND DILATATIONS OF RIGHT SIDE OF HEART.

In a paper read before the Section of Therapeutics of the Pan-American Congress, Dr. I. E. Atkinson, of this city, says:

Engorgement and distention of the right side of the heart are not very prone to occur so long as hypertrophy of the ventricle is able to supply an increased energy sufficient to afford compensation to the obstructed circulation in front of it. It is only after failure of this muscular hypertrophy has begun, and weakening of power with dilatation and increased capacity of the vertricular chamber have set in, that the condition we are considering is apt to arise. This usually occurs by a gradual development after a long standing and slowly augmenting valvular defect, but it not infrequently is precipitated by sudden intervention of obstruction in excess of

that already present. The most important of these intercurrent processes maybe located in the lungs, as from a pneumonia, a bronchitis, especially in the presence of old emphysema. However occurring, whenever this condition is encountered, venesection affords a remedial measure of remarkable power; but where the engorgement is the consequence of a rapidly developing obstruction to an already laboring right ventricle, its good effects appear at times to be almost magical. The clinical indications for vensection under the circumstances we are considering may be quoted from an excellent paper on the therapeutic value of venesection, by Dr. Pye-Smith, as "general venous congestion with arterial anæmia indicated by *cyanosis* with dyspnœa, turgid veins, swollen liver, albuminuria, pulsation in the jugular veins and at the epigastrium, functional incompetence of the tricuspid valve (sometimes indicated by a systolic murmur), and a weak, small and fluttering radial pulse." The pathological chain of which these symptoms are the expression usually begins with an arterial anæmia having its origin in an unfilled or an imperfectly emptied left ventricle; unfilled, in consequence of an obstructed mitral orifice or an obstructed pulmonary circulation; imperfectly emptied, in consequence of an insufficient mitral valve. The blood, obstructed in its onward passage in one or the other, or all of these ways, banks up into the system of the right heart, the pulmonary artery, the right ventricle, the right auricle, and into the general venous system. The brunt of the struggle is with the right ventricle which, unable to overcome the obstacle in front by its systole, distended during diastole by the increasing pressure of blood from behind, becomes overfull, stretched, incapable of orderly and vigorous contraction, and in immediate peril of succumbing to the burden thrown upon it. As the distention of this muscle increases, so does its power steadily diminish.

Many therapeutic measures are resortedto for the relief of this condition of passive engorgement, with greater or less success, but no measure will so safely, so pleasantly, so speedily, so frequently afford relief, even avert impending death, as the judicious practice of venesection. By it the torrent of blood is checked and partially diverted, the ventricle, relieved of the pressure, contracts, gathers force and rhythm, and relief, often but temporary, rarely permanent, is secured. Naturally, in many cases all remedies fail and the patient dies; in many, again, the relief is only transitory; but in a fair number, where the circulatory obstruction is acute, as in the sudden bronchitis that at times surprises an old emphysema, with its resulting weak heart, the relief will be permanent. Taken altogether, I desire to claim openly that in the conditions above described, where the danger to the life of the patient is rapidly developed and imminent, the letting of blood offers greater chances of relief than any other remedy.

LEVULOSE IN DIABETES.

Attracted by the favorable reports of German observers, I have for more than a year been administering levulose to diabetic patients. I shall elsewhere publish a detailed report of my observations. In these notes it will suffice to say that in nine cases, including different types

of the affection, I have found that levulose may be administered in moderate quantities to diabetic patients without increasing the excretion of sugar or of acetone in the urine, and in some cases with a diminution of the quantity of sugar excreted. For example, to a patient who had for some time been excreting about four ounces of dextrose daily; one or two ounces of levulose were given daily for three weeks. and the excretion of dextrose fell to less than three ounces. Diminution of thirst and gain in weight were concomitantly observed. In cases attended with emaciation, the substances should be administered in quantities to be determined according to the amount of sugar excreted and the influence exerted upon the nutrition, as shown by the body-weight. In other cases it may be used as a sweetening agent. The greatest drawback to its use is its comparative costliness, the commercial product, to which, unfortunately, a trade-mark name has been attached by the proprietors, retailing at present for about three dollars a pound. This, however, is a great reduction from the cost of levulose when Kuelz first advised its use twenty years ago. One hundred dollars a pound was prohibitory.—Dr. S. S. Cohen, in *Med. News.*

THE TREATMENT OF PNEUMONIA.

Dr. H. A. Hare (*Medical World*) bases the treatment of pneumonia upon a recognition of the general condition of the patient rather than upon the cause of his illness. If the patient has been strong and healthy until attacked and is seen within a short time after the initial chill and the consequent rise in bodily temperature, it will be found that his pulse is full and bounding, the cheeks flushed and the respiration somewhat rapid. At this time, and no other, is aconite, veratrum viride, or antimony indicated, and they should be given fearlessly while they are given. From two to three drops of the tincture of veratrum viride or a similar quantity of aconite, preferably the former, are given every half hour until the decrease in pulse rate and pulse force and appearance of a slight perspiration indicate that the full influence of the drug has been exerted. If veratrum viride has been given early enough it is certainly competent to abort an acute croupous pneumonia occurring in a previously healthy individual. If it is not given early enough the result of its administration will be to hurt the patient. If there is marked dulness on percussion, with blowing breathing and the typical, fine crepitant rale of pneumonia, the use of these cardiac sedatives is contra-indicated in most cases, because the disease has become thoroughly instituted and the stage is past when the remedy can do the patient good. Where there is tendency to cardiac failure and the apex beat of the heart seems at all muffled or feeble, digitalis is indicated. The best results from its administration will follow its use in the dose of not less than 10 minims every 8 hours rather than smaller doses frequently repeated. Particularly is digitalis indicated if the pulse seems feeble. Where the skin has a tendency to be moist and the pulse, although large in volume, from the action of digitalis, seems to be surrounded by a relaxed arterial wall, the tincture of belladonna in the dose of five drops is a good additional remedy.—*Pittsburg Med. Review.*

COMMON MISTAKES OF DOCTORS.

1. To allow yourself to be agitated by the criticisms or praises of the patient's friends.

2. To allow yourself to make a display of your instruments.

3. To allow yourself to experiment or exhibit your skill uncalled for.

4. To allow yourself by look or action in a consultation to show that you are displeased, and that if you had been called first matters would have been different.

5. To allow yourself to indulge in intoxicating beverages.

6. To allow yourself to rely wholly upon the subjective symptoms for your diagnosis.—*Dietetic Gazette.*

SWAM THE STRAITS OF MESSINA.

Dr. Judson Daland, of this city, who recently went to Italy to investigate into the causes of cholera epidemics, has performed a feat that surpasses Byron's famous swim across the Hellespont. A friend has just received a letter from him telling of his achievement recently in having swam the Strait of Messina, or what was known to the ancients as the whirlpool between Scylla and Charybdis.

"It occurred to me that it would make a good swim," writes Dr. Daland, "more especially as the hotel keeper, who had lived in the little fishing village called Faro for thirty-two years, told me that no one had ever swam across, in the memory of the oldest inhabitant, although many tried and failed, including the hotel keeper himself.

"I took to the water at 4.10 P.M. and arrived in good condition on the Italian shore at 6.30 P. M., a distance of six or seven miles. I started from the Sicilian side at Faro, which corresponds to the Charybdis of the ancients, passed the rock called Scylla, and was forced by the powerful current to make a landing at a little village called Riggio, on the Italian shore.

"The entire swim was made without rest or stimulants, and I restricted myself to the breast and side stroke, not using the back at all. I encountered during the swim strong currents, running apparently in all directions, the direction changing every few moments. These currents were at times warm and at others icy cold. There was a high wind and a choopy sea, making it extremely difficult to breathe. I returned to Messina in good condition, and that same evening went to the opera."—*Med. and Surg. Rep.*

HICCOUGH.

R.—Bismuth. subnitr., gr. xij.
Zinci oxidi, . . .
Zinci valerianat., .
Pulv. calumbæ, . ʒj.
Pulv. opii, . . gr. iss.
Spirit. anisi, . . q. s.

M.—Sig.: Teaspoonful in a glass of sweetened water.—*Ibid.*

FATAL FOOT-BALL ACCIDENTS.

At a game of foot-ball between high-school boys in Adrian, O., last week, one of the players was killed by having his cervical spine dislocated while "downing" the ball. This is the fourth fatal injury at foot-ball this year, three other players having had their necks broken and one his skull fractured. A sixth, probably fatal case, occurred in Farmington, Conn., on the 20th inst., in a game between the Yale Senior Class team and the Farmington Athletic Club. One of the players on the latter team had his

neck broken, and is unconscious, and totally paralyzed below the seventh vertebra. In England the deaths from injuries received in the season from September 1st to April 1st are said to have averaged twenty-four in each of the last three years.—*Boston Med. & Sury. Jour.*

NASAL CATARRH.

Professor C. A. Wilson, of St. Louis, frequently uses the following, which can be varied to suit the case:

℞.—Liq. alboline, . . ℥ij.
Oil eucalyptus, . . gtt.x.
Terebine, . . ℥ss.
Menthol, . . . gr.v.
Oil gaultheria, q. s. to scent.

Use in compressed air spray.—*St. Louis Clinique.*

THE ORIGIN OF CIRCUMCISION.

LaMedicine moderne states that at a recent session of the Paris Society of Anthropology the question of the origin of circumcision was discussed. M. Letourneau recalled the custom of the Egyptians of practising phallotomy on the vanquished. This custom still persists in our day among the Abyssinians. Every warrior who has killed an enemy, says James Bruce, presents to the chief a bloody prepuce. The ceremony being concluded, each warrior gets back his bloody trophy, and, taking it home with him, prepares it in the same fashion the Indians employ for scalps. This custom existed among the Hebrews, and to become the son-in law of Saul, David had to bring in the foreskins of a hundred Philistines.

Ritual circumcision is thus derived, and was an act of homage to God. The usage of offering portions of the body to the gods has been and is yet very widespread. It is a symbol of a complete sacrifice that has become partial by the lessening rigor of morals. It is thus that blood or the fingers were offered, or the sacrifice of their hair, by the early Christians.—*N. Y. Med. Jour.*

FATTY DEGENERATION OF THE HEART.

Goebel (*Centralbl. allgem. Path.*, September 27th, 1893) makes a contribution to this subject, based upon careful examination of fifty-eight hearts. His main conclusions are as follows: (1) The degeneration appears first in foci; these gradually increase in size and run into each other. But, notwithstanding this diffusion, foci, where the degeneration is most intense, remain visible. (2) The fat droplets occur only in the interfibrillary sarcoplasm; for this reason they are found disposed in long rows. (3) The transverse striation of the muscular fibres is not essentially affected in fatty degeneration, but becomes obscured in advanced states by the deposit in a longitudinal direction of the fat droplets. (4) The *myocardite segmentaire* of Renaut is found relatively frequently in conjunction with fatty degeneration, especially in the early stage of the latter. (5) When, owing to valvular disease or other cause, a one-sided hypertrophy, or other one-sided affection, has resulted, coexisting fatty changes are by no means limited to the affected side; they are often quite diffuse, the whole heart being involvod. (6) Diffuse fatty degeneration due to some general cause is seldom equally pronounced over the whole heart; it is generally most marked at certain parts, for no obvious reason. (7) The degeneration is especially pronounced immediately beneath the epicardium and endocardium.—*Brit. Med. Jour.*

CHICAGO PASTEUR INSTITUTE.

Since the inauguration of the Chicago Pasteur Institute, July 2, 1890, 302 persons have been treated by preventive inoculation against hydrophobia; 104 were bitten by animals recognized and ascertained to be rabid by the experimental proof made in the laboratory, or by the death of other persons or animals bitten by the same animal; 126 were bitten by animals recognized to be rabid by the symptoms of the disease shown during life, and 72 by animals strongly suspected to be rabid; 282 persons were bitten by dogs, 7 by horses, 7 by cats, 3 by skunks, 2 by wolves, 1 by a mule. The persons treated came from the following States: 185 from Illinois; 32 from Iowa, 23 from Indiana, 21 from Kansas, 9 from Ohio, 5 from Missouri, 5 from Arizona, 4 from Minnesota, 4 Michigan, 4 from Louisiana, 3 from Tennessee, 3 from Kentucky, 2 from Texas, 1 from Wisconsin, 1 from South Dakota. One death was reported among the patients treated, thus giving a mortality of only 0.33 per cent.—*Boston Med. and Surgical Journal.*

PREGNANCY AFTER THE REMOVAL OF ONE OVARY AND PART OF THE OTHER.

Sippel reports a double ovariotomy in a woman thirty years of age, who had one child five years old and was very anxious for another. The right ovary was converted into a tumor the size of a child's head, and without a trace of normal ovarian tissue. This was removed with its tube. The other ovary was the size of a goose egg. Along the hilum was a long tract of normal tissue. A clamp was applied above this tract to check hæmorrhage and the diseased part of the ovary cut away; the raw surfaces left were united by means of catgut sutures, while some blood vessels were tied separately. The healthy part was an inch and a half long and a third of an inch thick; the left tube was undisturbed. Menstruation returned after the operation, and ceased on the 22nd of August, 1891; on the 7th of April pregnancy was progressing favorably, and she was safely delivered of a living child.—*British Med. Journal.*

FOR INGROWING NAIL.

To expedite the process of healing, following the performance of the radical operation for ingrowing toe-nail, Hübscher (*Corr.-bl.f. Schw. Aerzte*, 1893, No. 20, p. 695) recommends the transplantation of healthy skin to fresh wounds. His course of procedure is as follows: Cocain is injected into the toe to be operated on and also upon the antero-external aspect of the corresponding thigh; then a compressing bandage is applied at the base of the toe, the nail divided, its two halves removed, together with the lateral and posterior portions of the ungual fold; the nasal matrix freshened; the bandage removed; hæmorrhage controlled, and a layer of skin transplanted from the thigh. Finally, a dressing is applied and permitted to remain for three or four days. The wound practically heals by first intention. As a precaution an iodoform-collodion dressing should be continued for a few days longer.—*Med. News.*

CONCEALMENT OF SEX.

A case having some scientific interest in its bearing on the question as to whether secondary sexual characters are

inherent or acquired has recently been investigated. An individual known as "Jack Jorgensen," and employed for many years as a farm laborer at Elmore, Victoria, died suddenly, and the body was found to be that of a woman. Jorgensen's real sex had never been suspected. She had been in the Mounted Rifles, and was noted for her capacity for hard work. She was very unprepossessing in features and rough in manners, so that she was unpopular in the district and had no intimates.—*Lancet.*

DUBOISIN IN MENTAL DISEASES.

Mongeri has written a monograph on the above subject (Milano, Tip. Capriolo, 1893). He had abundant material for observation at the Ospedale Maggiore of Milan, and comes to the following conclusions with regard to its use: Duboisin should be used as a sedative in the maximum dose of 1½ millig. and a minimum of ½ millig. It is preferable to the other sedatives on account of its prompt action and the ease of its administration. It should, however, be used by preference in the evening, in order to combine the effects of the natural inclination to sleep with the sedative effects of the drug. The drug may be employed, says the author, in all forms of active insanity, especially in furious mania and acute alcoholism; it is useless, however, in the asthenic forms and those accompanied with depression.—*Brit Med. Jour.*

A DOCTOR WITH EXPERIENCE.

One day while mending the roof of his house Chodja lost his balance and, falling to the ground, broke a rib. A friend of his went hurriedly for a Hakim (doctor).

"Hakim, have you ever fallen from a roof and broken a rib?" was the first question Chodja asked the doctor.

"Thank God, no," replied the Hakim.

"Then go away at once, please," cried Chodja; "I want a doctor who has fallen from a roof and knows what it is!"—*Good Words.*

Recommendations of Therapeutic Agents.

Losophan in Dermatology.—Losophan is described as a stimulating topical application which acts also as a detergent and parasiticide. It has great power to arrest the development of bacteria, and to destroy a great variety of viable disease-germs. This quality is due alike to the richness of losophan in iodine and to the fact that its basic component is cresol, the chemical name for the new remedy being triiodemetacresol. Therapeutically, losophan exerts a favorable influence in the parasitic affections of the skin of most common occurrence, such as herpes and pityriasis versicolor, as well as in cutaneous diseases due to the action of animal parasites. In some of these cases a complete cure has been obtained. Losophan has also given successful results in prurigo, chronic infiltrated eczema, sycosis vulgaris, acne vulgaris, and rosacea. Its use seems contra-indicated in all acute inflammatory diseases of the skin in which it naturally provokes some irritation, since it relies upon its stimulating powers in inciting a return of the skin to its normal condition. In all mycotic conditions losophan has been very successfully employed.

Medical Items.

Virchow celebrated, on October 21st, the fiftieth anniversary of his accession to the doctorate.

Dr. Benjamin H. Kidder, recently a medical inspector in the navy, has received his promotion to the grade of medical director.

The number of women in the Medical Department of the Michigan University is larger than ever, as also in the Literary Department.

Dr William Henry Broadbent has been appointed as physician to Premier Gladstone, vice Sir Andrew Clark, deceased.

It is announced that the Russian Government contemplates inviting the Twelfth International Medical Congress to be held in Russia, probably at St. Petersburg.

An effort is on foot in Brooklyn to establish a non-sectarian home for epileptic patients. A suitable lot has already been secured, and it is desired to raise a building fund of not less than $10,000.

The cost of a medical education, according to the *Hospital*, is, in London, $400 to $500 per year, for five years, plus $700 to $1,000 in fees, making a total of $2,700 to $3,500. In New York it would be $600 a year for three years, and $300 for fees as a minimum estimate.—*Med. Rec.*

The Boston City Hospital secured a medal at the World's Fair for the excellence of its exhibit. The exhibit consisted of plans, photographs and other objects of interest in connection with the hospital service.

Dr. A. Naumann, of Berlin, has found that the milk sugar of the shops is frequently contaminated with microorganisms having their source in the milk used in the production of the sugar. He has found that sterilized milk is coagulated after the addition of sugar of this nature.

Dr. Playfair, who recently attended the Princess Marie, of Roumania, in confinement, was presented by the king with a gold snuff-box and the insignia of a Grand Officer of the Order of the Crown of Roumania, in addition to his fee, which is said to have been £2,000.

Dr. Levi C. Lane, of San Francisco, has presented to the city of San Francisco a large building with two wings, each two stories high, which he has had built for a fully equipped hospital, to be used as an annex to the Cooper Medical College of that city.

The number of matriculated students in the universities of the German Empire in the summer semester of 1893 was 28,053, of whom 8,838 were students of medicine. The number in the corresponding part of the foregoing academic year was 8,414, showing an increase of 424, or 4.8 per cent. The number of foreign medical students was 474.

In the official census reports of the Registrar-General's office of England, the medical profession, which in legal language means only medical practitioners on the Register, is made to include dentists, dental-apparatus makers, medical

students, assistants, midwives, nurses, and invalid attendants, *as well as sundry other persons more or less directly connected with medicine.*"

The new hospital annex of the Cooper Medical College of San Francisco will be opened during next summer. The building will cost somewhere in the neighborhood of $150,000 and will have a capacity of 100 beds.

The census of the medical profession of Great Britain makes the total number of members of the medical profession 85,235. But of these, 30,843 are males, 54,392 females, the latter including midwifes and nurses! The English census thus puts nurses in the medical profession ; the London directories class physicians among the tradesmen!

In the past summer semester the total number of female students in the five universities of Switzerland was 275. Of these, 121 were students of medicine, who were distributed among the various schools as follows:—Bern, 47; Zurich, 40; Geneva, 26; Lausanne, 5; and Basel, 3.

At the recent meeting of the Saturday and Sunday Hospital Association it was shown that during the year the total expenses of maintaining the thirty-one hospitals under the Association's management had been $1,173,474.32. The thirty-one hospitals received 20,691 patients, of which number 15,417 were treated free, including 193,099 out-door patients. And yet the younger doctors complain of the hard times !—*Med. Rec.*

The jury in the $25,000 damage suit of Miss Caroline T. Doss against Dr. Archibald B. Earl, of Kansas City, returned a verdict for the defendant, in Judge Slover's Court, Nov. 3rd. Miss Doss broke her arm in 1892. She procured the services of Dr. Earl to reduce the fracture. She alleged that the arm was crooked to the extent that she was maimed for life. Miss Doss is 68 years old and Dr. Earl, the defendant, is 75, and retired from practice years ago. He set up as defense that he set the arm purely as an accommodation, as he had retired from practice at the time. He further alleged that the plaintiff was responsible for the deformity, as she did not protect the arm properly after it was set.

The *Cin. Lancet-Clinic* says: The United States annually expends more than $700,000 for the investigation of diseases of domestic animals, and Congress is too parsimonious to spend $30,000 for the sustentation of a cabinet officer of public health and the necessary office force to make the department effective for the preservation of the lives and health of sixty millions of human beings. This condition of downright ignorance is in the face of the fact that an epidemic of cholera this year in the city of Chicago alone, would have cost the Nation more than $100,000,000 in cash money, besides the lives of numerous victims of the disease;and yet it can be truthfully stated that scientific medicine stood as the great barrier to this threatened invasion of an army of microbes, whose invisible columns would have shattered and despoiled every barricade that could have been raised by the greatest engineers, architects, generals and admirals in America. This invasion was stopped by medical science, which, to the disgrace of our country, had a beggarly support.

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DISAGREEABLE EXPERIENCES IN GYNÆCOLOGY.*

BY WM. PAWSON CHUNN, M. D.,

OF BALTIMORE.

It has been said, Mr. President, that when the diagnosis is made, the patient is already half cured. Similarly, in the writing of a paper it may be stated, when the subject is chosen the paper is already half written. In this regard, among other things the question comes up whether a man will write from his own experience or from the experience of some one else.

The settlement of this question should be determined, on the one hand, by the experience he himself has had personally, and, on the other hand, by what he has seen others do, or read of in books. To use both of these sources would seem to me to furnish the best results. The fact remains, however, that one's own efforts and experiences make the most vivid impression on the individual's mind, and so naturally we find it easier to write our own impressions than to hunt up those of other people. For this reason, then, the remarks I have to make will be somewhat of an individual experience where, in consequence of adverse fortune, my position was not a happy one.

In regard to operative procedures I may say I have endeavored to assume no responsibility which was not necessary. On the contrary, I have always acquainted the patient with the risk she ran, and what per cent. of mortality followed each particular operation.

*Read before the Gyaæcological and Obstetrical Society of Baltimore.

The patient was then allowed to accept or decline as she saw fit. In spite of similar precautions with non-capital operations I remember by way of illustration a case of procidentia uteri where my efforts resulted in mortification to myself as well as to the cervix uteri of my patient. This unfortunate carried her uterus between her thighs instead of in her pelvis, was immensely fat and the possessor of an enormous abdomen. Altogether it was the most unpromising case of the kind I had seen. The cervix was split, hypertrophic and greatly elongated.

At the time referred to the use of pessaries was more fashionable than at present. I therefore decided to try the effect of one of these instruments, and selected one consisting of a ring supported by a stem, said stem to be held in position by divers cords, rubber bands, etc., etc., which in turn were attached to a belt around the waist. The instrument was finally adjusted. After five days the patient returned with indignation and pain about equally proportioned. Examination showed that the cervix had slipped through the ring and had been constricted in such a manner that sloughing was imminent. The ring was so embedded in the tissues that I borrowed a pair of stout bone forceps and after breaking it in pieces succeeded in liberating the cervix. I have already said that I felt mortified. Shortening the round ligaments in this case might have proved beneficial, the methods by abdominal incision might have proved successful, but I think the only sure cure would have been amputation of the uterus. On another occasion I was disagreeably surprised by an unforeseen incident which occurred during an examination. The patient was thin, with very lax abdominal walls, but on account of pelvic complications it was found difficult to determine the position of the fundus uteri. To decide this question a Simpson's sound was inserted in the cervix and easily traveled upward until its tip end was plainly felt through the abdominal wall just below the umbilicus. The sound had evidently passed through the uterus with about the same celerity as a nervous chill passed through my system. This experience was new to me and at the time I was unable to offer any explanation. I was not at that time aware that in some cases a metro-peritoneal fistula exists through which an instrument may be easily passed into the abdominal cavity without injury. This patient was subsequently examined and always with the same result.

The history of the case just related recalls a somewhat similar occurrence which happened about the same time. An under-graduate in medicine was attending a labor case and for certain reasons decided to apply the forceps. This he did, making traction with such force and dispatch as speedily enabled him to pull the head clean off the shoulders, leaving the child's body still within the parturient canal.

A further effort having failed to deliver the body, assistants were sought for in order to release patient and practitioner from this disagreable condition of affairs. A member of this Society responded and succeeded in effecting the delivery. I believe the placenta was also gotten safely away. The woman survived the manipulation, and on account of subsequent hæmorrhage was curetted.

Shortly afterward she passed into the hands of an obstetrician and through his kindness I had an opportunity to examine her. I easily passed two fingers through the patulous cervix and thence into the abdominal cavity, where the convolutions of the small intestine were distictly felt.

Two questions appeared for solution: 1st. How had this opening been made? 2d. In what way should it be treated? It was thought at the time that the curette was responsible for the rent in the uterus, and that the expectant plan of treatment would furnish the best results for closure of the same. This proved to be so and the woman was finally discharged cured. In reflecting upon the cause of the uterine laceration, however, I think it quite possible that the fundus was ruptured during labor.

The parturient act was tedious, with hæmorrhage occurring after the delivery. Possibly other signs of rupture were present unrecognized by the under-graduate in attendance. The fact that the body of the child could not be extracted even after the head was delivered would also give support to this theory. It is also possible that the uterine substance was perforated by the action of the curette, or it is conceivable that a blade of the forceps may have been forcibly pushed through the parenchyma of the organ, but with these two last named accidents I am thankful to say I have had no experience nor do I know any one that has had any.

The case related was followed by one in my own experience which for the time subjected me to considerable uneasiness. The patient, a married woman, and the mother of children, had passed the menopause, but latterly was afflicted with distressing menorrhagia. Examination showed epithelioma of the vaginal portion of the cervix. This I amputated, and to prevent hæmorrhage, packed the vagina with cotton so as to fully distend that organ. In preceding cases of this kind I had always used liq. ferri. subsulphate as an application to the bleeding stump to stop the hæmorrhage. This drug seemed to me to be not only efficacious in controlling the hæmorrhage, but by its power to coagulate albumen it formed stoppers, so to speak, in the mouths of the vessels and so prevented ingress of sepsis. However this may be, I know that in the cases where the iron was used, I did not have sepsis and in the single instance where I omitted it I did have sepsis.

The operation being concluded, the patient was put to bed and directions were given to take out the cotton in the morning, and orders were given to the medical man to use antiseptic vaginal douches. On the third day I was summoned in haste, to find Mrs. X with a temperature of 106, with a prospect of a speedy death in the near future.

The attendant said the treatment ordered had been carried out and that vaginal douches had been given every three hours. Upon examination, I found to my surprise that the vagina was still filled with the cotton I had first put in; that owing to the cotton packing the disinfecting fluid had not even entered that organ and that the foreign material had simply acted as an obstruction whereby decomposing fluids were dammed back and absorbed in the system.

I may say here that I have always taken credit to myself for the manner in

which I concealed my angry passions at the neglect with which this poor woman had been treated. I immediately took out cotton a great deal faster than I put it in and proceeded to administer an antiseptic douche, myself. This was followed by an immediate fall in the temperature, and convalescence was from that time on quite rapid. I do not know whether the trouble returned or not.

A case in abdominal surgery sometimes occurs where, in spite of every effort to prevent injury, disagreeable results will occur. At times important viscera are damaged or ruptured and even though all care is taken to repair and stitch up such openings, unforeseen accidents will occasionally prevent success. This was most forcibly impressed on my mind by the following case: In removing an ovarian cyst, which was strongly adherent in one place to the lower part of the colon, the gut was badly torn. The accident was recognized and the opening was at once carefully stitched up.

Although the mistake was not in itself the cause of the patient's death, yet in the fulness of time an autopsy was held, showing the following condition: The torn portion of the intestine, upon being closely examined, disclosed the fact that the stitching entirely closed the canal, so that nothing could by any possibility pass through it. Had this patient recovered from the effects of the operation and had a secondary laparotomy been performed for intestinal obstruction I am afraid a most disagreeable state of affairs would have been found.

Although a number of accidents have occurred to me which I have not mentioned so far, I thought it well to bring the subject before the Society, even in part, choosing rather to continue this paper at a future date, under the same title.

AMŒBA COLI: OR THE REPORT OF A CASE OF AMŒBIC DYSENTERY.*

BY DAVID STREETT, M. D.,

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In 1859, Lambl found organisms, now thought to have been amœba coli, in the intestines of a child which had died of enteritis.

Lösch, of St. Petersburg, gave an accurate description of amœba coli, large numbers of which he found in a case of ulcerative colitis. He injected the stool containing the amœba into the rectums of dogs, and at the end of eighteen days found them in large numbers in the intestinal mucus and in an intestinal ulcer.

Koch, in 1883, during his researches in Egypt for the organism of Asiatic cholera, found amœba in sections of intestines of persons who had died of epidemic dysentery.

Kartulis, of Egypt, in 1883, found amœba coli to be invariably present in dejecta of dysenteric patients, and in the pus and walls of hepatic abscesses, occurring as a complication; he subsequently made cultures of this organism in straw infusion.

Osler, in March, 1890, discovered amœba coli in pus from an hepatic abscess, occurring in a gentleman, who had

*Read before the Baltimore Medical Association, November 12th, 1893.

suffered from dysentery while residing in Panama.

He found the organisms, in each examination, in pus from the drainage tube, during the fifteen days the invalid survived the incision of the abscess.

Dock, of Galveston, Stengel and Musser, of Philadelphia, Councilman and Lafleur, and Howard, of Baltimore, Eichenberg, of Cincinnati, Wasdin, of Charleston, and Nasse, have reported cases of dysentery in which they found this organism.

Amœbic dysentery prevails extensively in tropical and subtropical regions, less so in higher latitudes.

It is found in North America, Europe Asia and Africa, and probably exists in most countries of the globe. The amœba coli receives a description, in the main uniform, by all observers. This protozoon, in Leuckart's classification, is placed among the rhizopoda. It is probably one of the fresh water rhizopods. It has a diameter varying from ten to twenty micro-millimeters; is circular or ovoid in shape when resting, but when in motion changes its shape by extending processes known as pseudopodia; it consists of an endosarc, the central granular portion containing the nucleus and vacuoles, and an ectosarc, the homogeneous, hyaline or translucent sphere reminding one somewhat of an oil globule. The motile force of the organism seems to be inherent to the ectosarc. Seen beneath the microscope, its homogeneous protoplasm flows outward with a wave-like motion, forming pseudopodia of multiple forms and always bounded by curved lines.

The pseudopodia sometimes resemble simple bulging of the ectosarc; sometimes swelling of one extremity; sometimes a protrusion from one side, the pseudopodium, in many instances emerging from beneath a superimposing filmy layer of protoplasm.

Occasionally the organism thrusts out a large pseudopodium and then ectosarc and endoscarc flow into it, resulting in a change of position of the organism. It can thus move entirely off the field. If seen in the intestinal dejecta or pus of hepatic abscess, before they have cooled, they are usually moving actively; if seen after slight cooling they move sluggishly or not at all.

In some specimens they are numerous, three or four being found in one field; in others, several fields are scanned before one is found; and in some specimens in amœbic dysentery they are intermittently absent from the stools.

The endosarc sometimes contains bacteria among its granular contents.

Howard's monograph of December, 1892, affirms that the endosarc "often contains foreign bodies such as red blood corpuscles, pus cells, the nuclei of cells and bacteria."

Councilman and Lafleur found micrococci in the endosarc by staining with methylene blue.

The nuclei and vacuoles are still subjects of study by pathologists.

These unicellular organisms are comparatively easily differentiated from other cells.

The essential lesions of amœbic dysentery are ulcers, mostly in the large intestine.

These ulcers are preceded by general œdematous infiltration and local cellular proliferation, followed by disintegation and ulceration of the submucous connective tissue.

All the layers of the intestines are involved; the ulcers frequently open on the surface by small mouths, while their broad and irregular bases extend into the subjacent tissues.

The ulcers are sometimes joined at their bases by channels, tunnelling the superjacent-tissues, and leaving little healthy structure.

Amœba coli have been found in the walls of ulcers,in lymphatics and in blood vessels. With other organisms and detritus they reach the liver via the portal circulation and lymphatics. As a complication hepatic abscess occurs frequently.

In the fifteen cases reported by Councilman and Lafleur, it occurred eight times, or in 53 per cent. of the cases.

In Howard's two cases one had hepatopulmonic abscess, with expectoration of amœba, and the other, on which no autopsy could be obtained, had the symptoms and signs of abscess. Osler's Panama case had hepatic abscess.

We may fairly conclude 11 of the 18 cases above quoted had hepatic abscess, a rate of over 61 per cent. In these 18 cases perforation of the lung occurred 7 times,an average of about 39 per cent.; in India the average is about 23 per cent. In one of these cases, recovery ensued, after perforation of the lung, a mortality of over 94 per cent. in the Baltimore cases. This is of course too limited a number of cases from which to draw sound conclusions.

Hepatic abscesses caused by infection of amœba coli are single or multiple; the upper and posterior portion of the right lobe seems to be a favorite location.

Its convex surface in juxtaposition with the diaphragm, presents a favorable condition for the pulmonic invasion. Little is known respecting the source, origin, development, habits and precise geographical distribution of this organism. Observers generally are of opinion that it reaches the alimentary canal through the medium of drinking water.

We are not therefore surprised when we learn of the occurrence of amœbic dysentery in sections of the country where springs and wells are imperfectly protected from contamination, by surface drainage and washing; but we cannot so easily comprehend why cases occur in cities with good water supplies in individuals who have not been outside of the city limits, and who use no other water than that furnished in the general supply by the municipalities.

If these cases be contracted through the drinking water, thus obtained, it is a matter of serious public concern.

The following case which occurred in my practice seems, at first sight, to have been one of urban infection; the man had not been outside the limits of the city of Baltimore for seven years, except on one occasion, nearly five months prior to his illness,when he made a visit to New York City and Passaic, NewJersey.

Between his visit and attack of illness he enjoyed excellent health. The account of the case is as follows:

Mr. S. S., 58 years of age, born in Russia; has been in America fourteen years, the first six of which were passed in New York, the seventh in Richmond, Va., and the remaining six in Baltimore.

He went to New York in April and returnd to Baltimore about May 1st; He was taken sick on September 21st, more than four-and-a-half months after his return. Occupation, tailor; his

work-room is in second story front room, a large and well-ventilated chamber. He is a Hebrew; is married and is the father of ten children, eight of whom are living and healthy. He has never, until the present illness, needed the services of a physician. Has been a liberal drinker of hydrant water and has averaged one pint of whiskey and two glasses of beer per week. He has used alcoholic stimulants for forty years, and about the same quantity weekly, never becoming intoxicated. Drank kimmel for thirty years; the last ten years has used plain whiskey. Drinks no milk except what he uses in hot tea. He has smoked since boyhood and for many years has been a liberal consumer of cigarettes. Has lived in present residence, on Exeter Street, near Low, for the last three years.

On September 21st, 1893, he was attacked by diarrhœa, having eight or nine stools per day, described as feculent, yellowish, and at times bloody. Diarrhœa, with abdominal pains, continued; he remained in two rooms and refused to lie in bed, sleeping in bed at night and lying on lounge in the adjoining room during the day.

On October 15th I saw him for the first time, twenty-five days after his illness began; he died October 31st, sixteen days later, about the end of the sixth week. I found him lying on lounge; decubitus, right latero-horizontal, with head elevated.

He complained of pain in abdomen and had from three to five stools per day, some days, more. The stools were sometimes dark-greenish and at others yellowish, feculent and thin, with abundant mucus and some blood, with shreds of tissue and small grayish spots and of very offensive odor.

At my first visit his respiration was 24, pulse 110, temperature 102. I prescribed bismuth subnit., gr. xx, tinct. opii deodorat, m. xx, every three hours, concentrated liquid food and alcoholic stimulants. This was substantially the treatment, with slight variation, for several days.

On my visit next day, I found he had less pain, but had passed several small, bloody stools; pulse was then 120 and temperature 104. He said he had no chill; cheeks were flushed.

October 17th, no change, except that he had pain in right hypochondrium and in right lumbar region; stools less frequent; no cough, nor had he any at a subsequent period; no nausea.

Respiratory murmur and percussion note normal, except on the right side at base of chest, where dullness is present beneath angle of scapula and higher in sub-axillary line than normally found. The patient remained in this condition, having frequent stools some days, few on several days, but always mucoid and bloody.

He steadily grew worse, his pulse increasing to 124 and temperature varying from 101° to 104°. At no time was there any regularity in the rise of the temperature; chilly sensations occurred, but no decided chill. When the temperature was elevated in the afternoon, the cheeks were always flushed.

Skin tawny, but not jaundiced at any time. Dysuria was a prominent feature; urine high colored, but normal. Pain in the right hypochondrium increased; dulness rising higher posteriorly; hepatic dulness in mammillary line in-

creased; rounded margin of liver felt below costal border; diminished respiratory movement; diminished vocal fremitus; diminished percussion resonance; and absence of respiratory murmur at the base of the right lung pointed to pleuritic effusion. Between the spinal column and a line let fall from the lower angle of the scapula, there is a fair percussion resonance when compared with the subscapular dulness; this, of course, contradicts much pleuritic effusion. The liver is manifestly enlarged; its lower border is slightly tender on pressure.

October 25th, I introduced the needle of the hypodermic syringe, between the seventh and eighth ribs, outside of a line dropped from the angle of the scapula, and drew off cylinder of syringe full of clear fluid; microscopic examination showed it to contain few leucocytes; it was clear serum.

October 26th, 11 A. M., I introduced the needle of the aspirator in the seventh intercostal space, 16 c. m. from the spinal colum, at the same point as on the previous day, and drew off about 59 c. c. of clear serum. The flow ceased, and thinking the point of the needle out of the fluid, I introduced it slightly farther, when a flow of pus immediately followed. The pus was stringy, bloody and of a grayish granular appearance, and very tenacious. It ceased to flow, whereupon I withdrew the needle and introduced in same opening a larger one and drew off about 591 c. c. of pus, making, including fluid and pus, a total of 650 c. c.

The needle was not withdrawn until the pus ceased to flow. At the conclusion of the aspiration, the patient expressed feelings of relief.

The pus was so coherent it was difficult to pour out one part of it without all of it flowing out.

Twenty minutes after its withdrawal I examined it at my office and found it to contain numerous amœba coli; two or three were often found in one field, some resting and round or prolate; others were in motion, extending pseudopodia comparatively rapidly. All had the characteristic granular endosarc and homogeneous ectosarc, from which extended, at irregular intervals, pseudopodia.

Beside the amœba, the field contained red blood cells, detritus, serum and a few acicular crystals.

At 5 P. M. of the same day, invalid feels more comfortable; dysuria is marked as usual. At this time an examination of the chest showed the following:

Over left lung percussion resonance and respiratory murmur normal.

Right side of chest.—*Anteriorly:* Vesiculo-tympanite resonance at apex; exaggerated resonance above nipple. Dulness begins about 3 c. m. below nipple. Resonant between upper border of liver dulness and margin of cardiac dulness.

Posteriorly: Dullness extends nearly to angle of the scapula; moderate resonance between *this* dulness and the spinal column, *i.e.*, between line dropped from lower angle of scapula, and the spinal column. Marked anterior spinal curvature, from bending forward in tailoring.

Laterally: Dullness begins at seventh rib in axillary line; no œdema of chest-wall. Hepatic dullness, extends in mammillary line 16 c. m., beginning 3 c. m. below nipple and ending about 5 c. m. below costal border.

Mensuration of chest as follow: From a point over crest of spinal column to a

point over centre of sternum on a level with lower border of nipple, on the right side the tape-line shows the distance to be 485 m. m.; corresponding measurement on the left side gives us 467 m.m., a difference of 18 millimetres, or nearly ¾ of an inch.

The difference between the chest girth in inspiration and expiration is 5 m. m., or about 1-5th of an inch.

October 27th.—11 A. M., respiration 32, pulse 124, temperature 101°; passed a restless night; pain in right side renewed.

Had six stools since yesterday, fecal matter, mucus and blood; is stupid and apathetic; cheeks flushed and sallow; Made microscopic examination of stools and found numerous motionless amœba.

Opium and stimulants continued, and prescribed injection of quiniæ sulph., gr. ii to aqua Oi, every 3 hours; on arrival in afternoon, found but one injection had been given because of distress it occasioned.

At 4 P.M. same day Dr. J. D. Blake saw the patient with me, the family declined to have abscess incised, even though his general condition at a future day should permit it.

Passed stool just before our arrival, in quantity about 15 c. c., only, and composed of mucus, shreds of tissue, blood and grayish masses.

Placing it in a bottle previously warmed, the bottle was placed in inside pocket to maintain sufficient heat, and we went at once to my office, two squares away, and examined the specimen on a warm slide, beneath microscope.

We found it to contain numerous active amœba coli; many were of maximum size, and actively thrust out pseudopodia; two or three, and sometimes four, were found in one field.

On evening of 26th of October, the amœba coli in the pus of hepatic abscess were exhibited, under microscope, at a meeting of the Medical and Surgical Society of Baltimore.

October 28th.—3 P. M., respiration 30, pulse 124, temperature 101.5 in axilla; passed a fair night. Dysuria still marked; bundles of tyrosin crystals and globules of leucin observed in urine; no albumen at any time.

October 29th.—1 P. M., respiration 22, pulse 124, temperature 97.9; had fair night; had five stools since the day before. Recent stool examined; it is blackened from subnit. bismuth; no active amœba found; all at rest and less numerous.

October 30th.—1 P. M., pulse 130, collapsed and unconscious; October 31st, died without regaining consciousness; could not obtain autopsy.

Comment.—It is a matter of regret that no autopsy could be obtained; in the absence of such, it must remain a doubt whether the dullness at the base of the right lung was due to enlarged liver and abscess wall pushing up the diaphragm and intruding upon the base of the pleural cavity; whether the diaphragm had been perforated, and the lower part of the pleural cavity, becoming sacculated (if not previously so), formed a part of the abscess wall; or whether with the intruding liver there was also pleuritic exudation, from circumscribed pleuritis, in the base of the pleural sac, causing dullness posteriorly.

To the latter condition I am inclined, because I had on the evening prior to aspirating withdrawn with the

hypodermic syringe serum, whose clearness and microscopic examination gave not the slightest indication of pus. The physical examination and clinical history of such a condition, accompanying dysentery, led me to diagnose hepatic abscess; but the unusual elevation of the dullness and the transparency of the fluid first withdrawn, led me to conclude that the dulness was partly due to fluid in the pleural cavity.

When, therefore, on introducing the needle of the aspirator, serum was withdrawn, the opinion of the day before was confirmed. But when the flow of serum ceased after the withdrawal of about 59 c. c., and believing this quantity was insufficient to cause such an extensive area of dullness, and that the point of needle had been displaced from the cavity, I thrust the needle farther in and a flow of pus followed, the primary diagnosis of hepatic abscess was confirmed in a very unexpected manner. There is little doubt but that the clear serous fluid came from the pleural cavity first punctured; and the pus from an hepatic abscess; the needle passing through a thin abscess wall, probably formed by the uplifted and bulging diaphragm. In the absence of an autopsy, the exact pathological anatomy must remain a matter of doubt.

A question of great interest in this connection is, *when* and *where* did this man contract this infectious disease? Could he have contracted it during his visit to New York and Passaic, N. J., nearly five months prior to his attack of illness, and the organisms have given no evidence of their presence in the intestinal canal? Could it have been contracted by contamination of milk, in some rural district, by using impure water in washing the cans or in diluting the milk? He drank no milk, except in hot tea. Could he have contracted it from hydrant water in Baltimore or New York? Could it have been contracted from eating market fruit and vegetables? Such seems unlikely, since both cities have large and good water supplies, with sources at considerable distance.

Too little is known of the natural history of this organism to locate it definitely; but the infection by fruit and vegetables seems unlikely, since pathologists are of opinion that it is contracted through the medium of the drinking water. The only other fluid this man drank was a pint of whiskey and two glasses of beer per week.

It is perhaps worthy of note that when in New York, as in Baltimore, he drank hydrant water from the regular municipal supply; he stated, however, that he drank water from wells as well as from the municipal supply, when he was in Passaic, N. J.

Could it have been contracted at the latter place, and the organism remained multiplying in the intestines, and have caused sickness nearly five months later?

Osler's Panama case looks as if such might be the case, since he resided six years in Panama; while there he had several attacks of dysentery, or rather chronic dysentery. He came to Baltimore in May, 1889, and then had recurring diarrhœa. He went to Europe and while there had several attacks of diarrhœa; he returned to Baltimore in December, 1889, still sick with occasional diarrhœa. Seven months after leaving Panama he was seized with irregular chills, fevers and marked diaphoresis,

these symptoms presumably marking the beginning of hepatic abscess.

What is the maximum and minimum period of incubation?

It is perhaps worthy of note that this case, like Dr. Howard's case No. 1, was of Russian birth; and like his case No. 2, an excessive cigarette smoker.

Arnaldo Maggiora, of Turin, Italy, from observations made in more than a thousand autopsies of fatal cases of epidemic dysentery, concludes that there is a type of dysentery caused by amœba coli that is likely to become chronic.

It is probable, amœbic dysentery occurs in our cities more frequently than is supposed, practitioners being too busy to make the necessary microscopic examinations; it is also probable that many mild cases recover without having been discovered. If severe cases occasionally recover, as in one case reported by Councilman and Lafleur, in which recovery ensued after the occurrence of hepato-pulmonic abscess, why may not much milder cases recover?

These cases suggest the importance of more work in an old field; the proper examination of intestinal dejecta in all cases of dysentery and irregular and chronic diarrhœa.

A NEW TREATMENT FOR PERTUSSIS.

Sidney B. Straley (*Times and Register*) advises the use of tincture of thymus serpyllum, made from the fresh green plant. He concludes as follows:

1. Thymus serpyllum is a specific for pertussis.

2. It acts in any stage of the disease.

3. It also is a nerve sedative and gastric stimulant.

4. It is necessary to use the green plant.

5. It is perfectly harmless in doses as large as a teaspoonful of the tincture for a child of eight years (usual dose xx m. to xxx m. of green tincture).

6. The action is fully established in twenty-four hours, and completed in five days.

7. Indications are that there will be no recurrence subsequently, at least not more often than in cases which run the full course.—*Archives of Pediatrics.*

DIABETES MELLITUS.

Professor Seegen, writing on the materials for the formation of sugar in animal organism, says: "Diabetes mellitus occurs in two forms; in one, the alimentary sugar alone is excreted, and on the exclusion of carbo-hydrates from the diet sugar disappears from the urine, and all other symptoms of diabetes cease; in the second form the excretion of sugar goes on when not a trace of carbo-hydrate is taken in with the food. These two forms are quite distinct in origin, course, and importance. I call the first the mild, the second the severe form of diabetes, and explain the facts by supposing that in the mild form the liver cells are not capable of forming glycogen or are incapable of holding it fast; in the severe form the tissue cells of the body have lost the power of decomposing the blood sugar, which consequently appears in the urine." It is in this severe form of the disease that Professor Seegen considers that he has proved by experiment that the fat of the food may serve as a source of some of the sugar excreted. —*Lancet.*

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BALTIMORE, NOVEMBER 25, 1893.

Editorial.

A BUREAU OF PUBLIC HEALTH.

The medical profession of this country has long felt the need of a bureau of public health as an independent department of the general government with an official head occupying a place in the President's cabinet. It has been argued that the public health is entitled to equal consideration with the army, navy and agriculture. Congress has vainly attempted to deal with the questions growing out of this important subject. Health laws have been enacted from time to time and attempts have been made to enlarge the scope and influence of legislation in a direction that would give greater recognition to the questions of public health, without satisfactory results.

Recognizing the vast importance of this subject, the Quarantine Committee of the New York Academy of Medicine has a draft of a Public Health Bill which it now presents to the profession for criticism and suggestions, with the hope that it will receive such support as will secure its enactment by Congress.

This bill has been drawn with great care and embodies the experience of practical sanitarians. The bill creates a Bureau of Public Health in the Treasury Department and not an independent Department of Public Health. In this respect it is disappointing, but its framers have been guided by practical considerations and believe that it is impossible to create a new Department until a demonstration has been made to Congress of the value and necessity of a special service. The Treasury Department has been associated with quarantine and the health of sailors and can approach the enforcement of a system of sanitary regulations with a practical experience.

The bill provides for a commission instead of a single officer. The members of this commission represent sanitary districts, not States, but the public health interests of every section are represented in the commission. An executive committee of the commission will be so located as to be in continuous session.

The commission will contain nine medical sanitarians, representing the sanitary districts, and they form the majority of the Bureau. One-third of these nine medical sanitarians retire annually and thus give continuity to the service. Two members are appointed at large (not necessarily medical men) with a term of service of six years, but one retires every three years.

The Quarantine Committee of the Academy of Medicine will present this bill to the next Congress and it requests

the cordial support of the various medical societies, health boards and other influences in their efforts to obtain its enactment.

In view of the importance of this subject, we urge the profession of this city and State to give proper consideration to the bill and to promote its passage.

THE RECENT SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND.

There are a number of members of the medical profession in this State who watch the semi-annual meetings of the Medical and Chirurgical Faculty with interest and pride. The success of these meetings is an encouraging indication of the growth of the work of medical organization in the State. Since the first semi-annual meeting held in Hagerstown in November, 1889, the following results have followed as an outcome of this work:

1st. The Faculty has more than doubled its membership. 2nd. A law to regulate the practice of medicine in Maryland has come into successful operation and is doing efficient work. 3rd. Local medical societies have been organized in Washington, Montgomery, Anne Arundel, Queen Anne, Kent and in several other counties in the State. 4th. The medical profession in the counties and in this city has been brought into closer and more cordial relations. 5th. The interest of the profession in questions of professional and public advantage has stimulated and developed.

No one can deny that such results are worthy of consideration. On the contrary, they give promise of more hopeful returns in the future and justify a larger interest in this work.

The recent meeting at Annapolis was without doubt the most successful of any previous meeting. It was more largely attended by both county and city members and more papers were read than at any previous meeting. The business and social features were of such a character as to command attention and give satisfaction to all present.

The general discussion of Dr. Preston's paper on "Some Facts and Suggestions Concerning the Care of the Insane in Maryland" brought out a very important sentiment in regard to the relation of the profession to questions of public duty towards the insane of this State. No question of public duty is more worthy of consideration at this time than the care of insane in Maryland, and it was very clearly shown that the profession of the State has a duty to perform in connection with this question which should be disregarded. Such discussions as this, and on kindred topics, at the meetings of the Faculty are to be commended on the ground that the medical profession of the State is in a position to lead public opinion in such matters of public duty more intelligently than any other class of men. The medical profession is charged with a responsible duty in connection with all questions of public health and public morals. It may evade such responsibilities by idleness and indifference, yet every one must feel that professional influence is lost and the public interests are sacrificed thereby. A more thorough organization of the profession of a community, State or nation directly tends to pro-

mote the study and consideration of those questions which bear upon the problems of good citizenship, of healthful homes and communities and of good morals. The discussion to which we have referred is worthy of all praise, since it indicates an advanced position of the profession of the State in relation to public matters.

Medical Progress.

TETANUS.

Vulpius (*Deut. med. Woch.*, October 12th, 1893) relates the following case with experiments. A boy, aged 11, fell from a tree and sustained a compound fracture of the lower part of the humerus. Four and a half days later, the first symptoms appeared, namely, trismus, rigidity of the neck, and, to a less extent, of the abdominal muscles. The wound was opened up, and a piece of stuff of the size of a pea and containing woollen fibres removed. The patient steadily got worse, and died fifteen hours after the onset. Morphine and chloral appeared to be of some service at first. At the necropsy, another piece of stuff similar to the above was found in the wound. A mouse inoculated from the pus died of tetanus within forty-eight hours. Tetanus bacilli were found in the pus from the inoculation wound. From the piece of stuff mentioned above inoculation experiments were made, and tetanus was induced. A piece of marrow from the humerus inoculated into a mouse caused tetanus. The experiments lead the author to think that the infection was conveyed by the piece of cloth. Experiments made with the patient's urine showed that the toxicity increased with the duration of the disease. Possibly by increased diuresis the elimination of the poisonous products may be promoted. Experiments were also made with the serum of the blood taken from veins of the arm shortly after death. Mice were injected, with the result that slight tetanic symptoms appeared with small doses and fatal tetanus with larger ones. No bacilli could be found at the site of inoculation, showing that this serum contained no bacilli. Experiments with the bile gave negative results. The symptoms were the same, whether the bacilli or their poisonous products (toxins) were used, but the incubation period was shorter in the case of the latter. Tables are appended showing the results of the experiments when material containing tetanus bacilli or urine and serum containing the toxins only were injected.—*British Medical Journal.*

EXPERTS MAY TESTIFY AS TO NECESSITY FOR THE REMOVAL OF AN EYE.

An expert in the treatment of diseases of the eye may testify in an action brought by a patient to recover damages from a third party for negligence resulting in an injury to her eye, that he removed the injured eye, which was totally sightless, to save the sight of her other eye, which was being impaired, and that he had her under his charge for several weeks, and had a distinct recollection of her case. And so may another expert testify in such case; the Supreme Court of Wisconsin holds, in Reed v. City of Madison, decided Sept. 26, 1893, that in his opinion it was necessary to remove the injured eye to save the sight of the other eye, which was endangered by sympathetic inflammation.—*Ex.*

DIAGNOSIS OF BREECH PRESENTATIONS BEFORE LABOR.

Pinard (*Rev. Medicale*) lays great stress on tenderness of the fundus. In some pregnant subjects who have passed the sixth month, pressure of the hand on the fundus causes sharp pain. Sometimes the patient feels pain without the part being touched. In both cases the evidence of breech presentation is strong. This pain, or tenderness, is solely due to the pressure of the fetal head, which is harder and more bulky than any other part of the fetus, and distends the upper segment irregularly. That segment is not naturally destined to receive the head. Pinard especially notes that the pain disappears after version. The tenderness is influenced by the size of the head, the amount of liquor amnii, and the flaccidity of the uterine walls. This tenderness of the fundus is present in 70 per cent. of breech presentations. —*Brit. Med. Jour.*

LOCOMOTOR ATAXY TREATED BY PHOSPHATIC INJECTION.

Dr. Forbes Winslow says in the *Lancet:* In June, I was consulted by the friends of a man aged thirty-four years, who was suffering from marked symptoms of locomotor ataxy. The complaint had been developing for the last two years, and the supposed cause was a fall from his horse in the hunting field. There was a complete want of coördination in his movements, he was quite unable to walk without the assistance of two sticks, and when seated in a chair could not raise himself without assistance. The case was a very characteristic one. I advised that a consultation should take place, and in the latter end of June I met the late Sir Andrew Clark, for that purpose. The patient was pronounced to have advanced tabes, and to be incurable. With a view of benefiting my patient I placed myself in communication with Dr. Brown-Sequard as to the organic injections, but in consequence of the friends objecting to this it had to be abandoned. Having heard, however, that much benefit had been seen from the practice, now gradually coming into vogue in Belgium, of treating tabes by means of phosphatic injections, I placed myself in communication with the leading physicians in Brussels, with the result that a consultation took place over there on the case. Having previously obtained the written opinion that in the numerous cases in which it had been tried no bad effects had ever been produced, I determined to give my patient the benefit of this new treatment. "Phosphate de soude" in combination was injected into the neighborhood of the spinal column by me fifty times, the opinion being that, if after this number there were no marked signs of improvement, no good would result. After the twenty-fifth injection most marked improvement became visible, and on the completion of the fiftieth injection my patient was completely cured. He could run up and down stairs, all the want of coördination had disappeared, there was positively nothing wrong to be detected in his gait, and all sticks and mechanical helps were thrown aside. A further consultation took place in Brussels on Sept. 23rd, when he was described as a marvellous case and his recovery was pronounced to be complete. Since I first became cognizant of the treatment I have tried it in other cases and, in all, the disease appears to be yielding to its use.

USE OF LIME WATER IN ARTIFICIAL INFANT FEEDING.

One reason why cow's milk is not easily digested by infants is that the casein formed by the action of the curdling ferment of the gastric juice is dense and tough, while that formed from human milk is flaky. The addition of lime water to the cow's milk causes it to be precipitated in flakes also, and thus overcomes this disadvantage to a great extent. A tablespoonful of lime water to an ordinary bottle of milk is enough, and a little sugar of milk may be added to correct the taste of the lime water. Courant (*Revue de Therapeutique Medico-Chir.*) has seen the best results follow this practice in gastric catarrh of children. —*Atlanta Medical and Surgical Journal.*

PROFESSOR GERMAIN SEE ON ULCER OF THE STOMACH.

At the last meeting of the Paris Academy of Medicine, Professor See's views on the nature, diagnosis and treatment of gastric ulcer were listened to with much attention. He distinguishes three forms of stomach troubles, viz.: 1. Hyperchlorhydria and "gastro-succorrhœa," which latter in nine cases out of ten is accompanied by the former. In this group he places ulcer of the stomach. 2. Abnormal fermentation, with or without generation of gases. This group includes *embarras gastrique* (acute gastric catarrh), chronic gastric catarrh, atrophy of the mucous membrane and cancer. 3. Nervo-motor dilatation without chemical complications. Of ulcers he distinguishes two varieties: the bleeding ulcer and the peptic ulcer without hæmorrhage. In the bleeding variety of ulcer the catheterism of the stomach with a view to analysing the contents for excess of acid must, of course, be conducted with very great precautions. Hyperchlorhydria having been found, the treatment must be directed to removing this condition. Antacids, alkalines and especially the chlorides of the alkaline earths, calcium and strontium, are to be had recourse to, together with what Professor See denominates a *regime lacte carne albumineux,* which uses up the excess of the hydrochloric acid present. The dry diet so often prescribed for the dilatation so frequently accompanying ulcer is hurtful, inasmuch as it tends to concentrate the gastric juice. The diagnosis of the non-hæmorrhagic variety of gastric ulcer is frequently far from easy, liable as it is to be confounded with such conditions as simple dilatation, dyspepsia, biliary colic and chlorosis. The principal means of diagnosis lie in testing for hyperchlorhydria. Peptic ulcer differs from simple uncomplicated hyperchlorhydria by the presence of the characteristic paroxysmal hatchet pains (*douleurs en hache*) and of repeated and serious vomitings. Gastro-succorrhœa (Reichmann's disease), which is mostly complicated with hyperchlorhydria, may be recognized by the hypersecretion and the pains occurring after an interval of several hours after a meal, when the food has already passed through the stomach. Œsophageal varix—the result of cirrhosis of the liver or of senile or alcoholic degeneration of the vein coats—may be mistaken for the bleeding form of ulcer of the stomach. Hæmorrhage from cancer is generally not profuse and the blood is not decomposed. Œdema of the legs after fatigue is especially frequent in cancer, even at the beginning of the malady. This phenomenon is rare in ulcer.—*London Lancet.*

CARBOLIC ACID.

Dr. L. Derville, of Lille (*Province Medicale*), reports success with carbolic acid in the treatment of vegetations on the genital organs. His experience leads him to urge the more general employment of this drug as a cauterant. There seems to be a diversity of opinion in regard to the indiscriminate use of this drug as a domestic remedy. At a recent meeting of the *Societe de medecine et de chirurgie pratiques*, at Paris, the consensus of opinion was decidedly against the use of carbolic acid as a household panacea, and the feeling was that, even in the hands of medical men, it was none too safe a remedy. M. Bardet reported the case of a child, three years old, who had been bitten on the finger by a wasp. A compress saturated with the acid had been applied, gangrene had followed, and a finger had to be amputated. M. Olivier had observed the case of a young man who had discovered a suspicious sore upon the glans penis, and had applied carbolic acid to the spot. A few days afterward gangrene of the prepuce had come on, producing a veritable circumcision.—*N. Y. Med. Jour.*

FRONTAL HEADACHE AND IODIDE OF POTASH.

A heavy, dull headache, situated over the brow, and accompanied by languor, chilliness, and a feeling of general discomfort, with distaste for food, which sometimes approaches to nausea, can generally be completely removed by a 2 grain dose of the potassic salt dissolved in half a wine glassful of water, and thus quietly sipped, the whole quantity being taken in about ten minutes. In many cases the effect of these small doses has been simply wonderful. A person who, a quarter of an hour before, was feeling most miserable and refused all food, wishing for quietness, would now take a good meal and resume his wonted cheerfulness. The rapidity with which the iodide acts in these cases constitutes its great advantage.—*Alienist and Neurologist.*

HOW TO EXTINGUISH FIRE.

Take twenty pounds of common salt and ten pounds of sal ammoniac (muriate of ammonia, to be had of any druggist), and dissolve in seven gallons of water. When dissolved, it can be bottled, and kept in each room in the house, to be used in an emergency. In case of a fire occurring, one or two bottles should be immediately thrown with force into the burning place so as to break them; the fire will certainly be extinguished. This is an exceedingly simple process and certainly worth a trial.—*Med. World.*

THE VALUE OF THE HANDS AND OF THE FINGERS.

Surgeons have often to estimate the chances of saving injured hands, and the comparative values of hands and fingers According to a scale of value furnished by the Miners' Unions and Miners' Accident Insurance Companies of Germany, the loss of both hands is valued at 100 per cent., or the whole ability to earn a living. Losing the right hand depreciates the value of an individual as a worker 70 or 80 per cent., while the loss of the left hand represents from 60 to 70 per cent. of the earnings of both hands. The thumb is reckoned to be worth from 20 to 30 per. cent. of the earnings. The first finger of the right hand is valued at from 14 to 18

per cent., that of the left hand at from 8 to 13.5 per cent. The middle finger is worth from 10 to 16 per cent. The third finger stands least in value; although like other useless members of the community, it is surrounded by riches, its value is only from 7 to 9 per cent. The little finger is worth from 9 to 12 per cent. The difference in the percentages is occasioned by the difference in the trade, the first finger being, for instance, more valuable to a writer than to a digger.—*Med. News.*

MORPHINE IN PUERPERAL ECLAMPSIA.

In a recent dissertation published by Kranz, under the direction of Veit, he gives the results of seventeen cases of eclampsia during pregnancy and parturition. All were treated in a similar manner by morphine. There were two fatal cases—one due to rupture of the uterus, and one to mitral stenosis with contracted kidneys. Four of the children were dead, in two of whom any deleterious action of the morphine was clearly ruled out. The effect which followed the initial dose, always 0.03 gm., was immediate and often lasting. If necessary the injection was increased gradually to 0.09 gm. in the course of nine hours. The largest amount given in any case was 0.095 gm., in two hours and a half.—*Boston Medical and Surgical Journal.*

TREATMENT OF DIPHTHERIA.

℞.—Phenic acid . . ℥ij.
Salicylic acid . . ℥iij.
Benzoic acid . ℥j.
Proof spirit . . ℥iv.

A tablespoonful in two quarts of boiling water to steam the room of the patient. It should be renewed every three hours.—*Med. Press.*

SUMMER DIARRHŒA.

℞.—Bismuth subnit. . ℥ss.
Tr. opii . . . gtt. xx.
Syr. ipecac,
Syr. rhei arom. . āā℥iv.
Listerine . . . ℥ss.
Mist. cretæ . . ℥j.

M. Sig.—Teaspoonful once in three or four hours for a child ten or twelve months old.—ROBERTS.

RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN.

The anual statement of the New York society for the relief of widows and orphans of medical men has just been issued, and from it we learn that there are now a hundred and forty-three members. During the year the society has extended aid to eleven widows and three children of deceased members. The admirable financial management has made a net increase of almost seven thousand dollars in the capital of the society, the total assets being a few hundred dollars short of a hundred and ninety thousand dollars. What a tribute these figures are to the good judgment and energy of the founders of an organization that is about to enter upon its fifty-second year! It is a matter of surprise that a society that offers so much to its members does not include in its membership the name of every reputable physician in New York. From a financial standpoint no better investment could be made than by joining it, and from a philanthropic standpoint the members of the medical profession should do all that lies in their power to relieve the destitute widows and orphans of deceased members of their guild.—*N. Y. Med. Jour.*

PETROLEUM IN VAGINAL INFLAMMATION.

Després (*Gaz des Hôp.*, June 15) has great belief in petroleum as a dressing. First, he found that it was preferable to coal tar and charcoal in the treatment of scirrhous ulcers in the breast. Then he obtained good results in cases of advanced uterine cancer, by injecting petroleum into the vagina. The foul discharges ceased at once. Now he finds that the same compound answers well for vaginitis. He uses 100 to 150 grammes of pure petroleum for one injection; it is in no sense a caustic. Two or three injections, one daily, will cure recent vaginitis. The petroleum adheres to the mucous membrane, and soaks into the tissues, so that it acts as a permanent dressing. The patients do not complain of the odor of the compound, and it in no way affects their health.—*Ex.*

THE TONGUE IN "LA GRIPPE."

"La grippe" is a disease which, simulating as it does various other pathological conditions, is often puzzling from a diagnostic point of view. Who, on being called to cases of "la grippe," has not thought of such possibilities as typhoid fever, acute tuberculosis, cholera, simple "embarras gastrique," &c. ? If one may believe M. Faisans (*Société Médicale des Hôpitaux*, May 19), examination of the tongue will disperse all such doubts. The tongue in "la grippe" is of the normal size and form, not being broad and thick, as in "embarras gastrique," or small, contracted and pointed, as in typhoid fever. It is always moist, unless some inflammatory complication be present or imminent; it is smooth and even, papillæ not being prominent. But the chief characteristic feature of the tongue is its color—it is the *opaline longue*. This opaline coloration is sometimes uniformly spread over the whole lingual surface; in other instances the middle and the base are opaline, the edges and tip being covered with distinct rounded opaline or bright red spots. This pathognomonic appearance may be often noted from the first onset of the disease and may persist for a more or less prolonged period after recovery. Purgatives and emetics do not modify it in any degree.—*Lancet* correspondence.

NAPOLEON THE FIRST'S MEDICAL ADVISERS.

From a curious work by M. Maze-Sencier, entitled "Les Fournisseurs de Napoleon I," we glean a few details concerning the *petit corporal's* physicians, surgeons, chemists, dentists, corn-cutters, &c., who cost him annually the sum of 201,700 francs. His chief physician (Corvisart) received 30,000 francs, *plus* 4500 francs for office expenses; Hallé, his physician-in-ordinary, received 15,000 francs; Lanfrancque, Guillouneau, Lerminier and Bayse, who took duty in turns at the Infirmerie Imperiale, were each paid 8000 francs; four other practitioners, who acted as consulting physicians (Malet, La Pieux, Pinel and Aubry), received each a salary of 3000 francs; the chief surgeon (Boyer) was paid 15,000 francs and the surgeon-in-ordinary (Yvan) 12,000 francs. It was Yvan who dressed Napoleon's wound at Ratisbon in the year 1809, and his portrait appears in Gautherot's picture—now at Versailles—of the incident. The four surgeons of the Imperial Infirmary were Horeau, Vareillage, Lacouenère and

Ribes, and the pay attached to their office was 6000 francs. Napoleon's surgeon at Saint Cloud, which he frequently inhahited, was Lassoujade, who received 4500 francs. Each of his consulting surgeons received 3000 francs; they were Pelletan, Percy, Sabatier and Dubois. It was Dubois who was in attendance on the Empress, Marie Louise, in her confinement. The process being long and laborious, he communicated his anxiety on the subject to the Emperor, whose reply was, "Faites comme si vous aviez affaire á une bourgeoise de la rue Saint-Denis; surtout, Dubois; sauvez la mère." The case did well, and the Emperor, delighted, told Corvisart to ask Dubois what reward he desired for his services. The latter, who was evidently a man of a practical turn of mind, gave the following modest reply: "Dis á l'empereur que je desire beaucoup d'honneurs et beaucoup d'argent." Let us hope that a *douceur* of 100,000 fr. and his elevation to the rank of Baron satisfied the cravings of the ambitious accoucheur for advancement. Napoleon had also his surgeon-dentist and his *chirurgien-pédicure,* whose salaries were respectively 6000 fr. and 2400 fr. Seven *pharmaciens*, one being at St. Cloud, received an aggregate sum of 23,000 fr. per annum. The Emperor professed a disbelief in medicine and frequent discussions on the subject took place between him and Corvisart, who, true to his courtier instincts,always allowed himself to be convinced by his Imperial master's arguments. Corvisart, however. had his revenge when he cured him of scabies caught at the siege of Toulon. The playful sarcoptes is evidently no respecter of persons.—*London Lancet.*

TRANSPLANTATION OF BONE IN THE RADICAL CURE OF HERNIA.

At the French Surgical Congress held recently a paper was read by Dr. Thiriar, of Brussels, on a new method of rendering the results of operations for the radical cure of hernia more durable. Owing to the yielding of the parietes at the seat of incision, relapses are unfortunately not uncommon after this operation. To remedy this inconvenience Dr. Thiriar proceeds as follows: The sac being opened and the stump reduced, he fixes with catgut sutures a plate of decalcified bone between the stump and the abdominal wall, the dimensions of the plate being proportional to that of the orifice to be obturated. In twenty-one cases operated on, a firm cicatrix has been obtained and no relapse of the hernial condition has been noted. Post-mortem examination in one instance showed that the plate becomes absorbed and is replaced by a resisting and hard cicatricial tissue.—*Ex.*

THE SAMUEL D. GROSS PRIZE.

The quinquennial prize of one thousand dollars under the will of the late Samuel D. Gross, M. D., will be awarded January 1st, 1895. The conditions annexed by the testators are that the prize "shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the successful competitor, who receives the prize, shall publish his essay in book

form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to Dr. J. Ewing Mears, 1429 Walnut Street, Philadelphia, before January 1, 1895.

Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

Medical Items.

Dr. Walter May Rew, of New York, whose bogus medical college was exposed last July, was sentenced October 10th to three months' imprisonment in the penitentiary.

Phthisical patients are henceforth to have special cars attached for their use to all passenger trains between Buda-Pesth and Gleichenburg, during the season at the latter place.

The trustees of the Massachusetts State Insane Asylum have voted to use the appropriation of $50,000 passed by the last Legislature for the purpose of erecting an addition which will accommodate fifty patients.

Professor Gairdner has been appointed by the Senate of Glasgow University to fill the vacancy on the General Medical Council caused by the retirement of Professor Leishman. The appointment extends over a period of five years.

On October 22nd a new Physiological Institute was opened in the University of Moscow. The Institute, the building and equipment of which cost 130,000 roubles (£13,000), is believed to be superior to anything of the kind at present in existence in Western Europe.

Dr. Charles Warrington Earle, President of the Chicago Medical Society, and one of the founders of the Chicago College of Physicians and Surgeons, died Nov. 19, of meningitis. Dr. Earle was a leading character, not only in Chicago, but in several national professional organizations.

Professor Henoch has resigned his chair in the University of Berlin, and his clinic of children's diseases in the Charite Hospital. The names of Professor Rauchfuss, of St. Petersburg, Dr. Jacoby, of New York, Dr. von Noorden, of Berlin, Professor Kohts, of Strassburg, Dr. Soltmann, of Breslau, and Dr. Eschenbach, of Graz, are mentioned in connection with the succession to the chair.

Some idea of the magnitude of the work of the Marine Hospital Service may be obtained from the fact that at the commencement of the fiscal year there was a balance available of $75,528.01, and that the receipts from all sources were $650,510.39; the expenditures were

$586,839.06; leaving a balance at the close of the year of $139,199.34.

A farewell banquet was tendered to Dr. Pozzi, the eminent Parisian professor, on his way through New York. The host was Dr. Paul F. Munde and the feast was served at the Union League Club. Among the other guests were many leading gynecologists and surgeons; Drs. T. G. Thomas, Lusk, Wyeth, Jacobi, Mann, Loomis and the officers of several medical organizations.

The well-known Professor of Surgery, Dr. Roswell Park, of Buffalo, has been sick with diphtheria, in consequence of contracting the disease from a patient on whom he had been called to operate. Dr. Park has our profound sympathy and our best wishes for his recovery from this disease, which has been of late markedly fatal among his surgical confreres.

Cleveland, Ohio, is dominated by homœopaths to a far greater extent than any city with which we are familiar. The *Cleveland Medical Gazette* has been studying this matter and finds the facts as follows: Of homœopathic physicians, Indianapolis has 4 per cent.; Columbus, 6 per cent.; Cincinnati, 7 per cent.; Chicago and Detroit, each 12 per cent.; St. Paul, 13 per cent.; Minneapolis, Pittsburgh, and Philadelphia, each 14 per cent.; while Cleveland has 26 per cent.

It will be gratifying to the numerous friends and patients of Sir Andrew Clark to learn that shortly before the death of the eminent physician, Mr. G. F. Watts, R. A., completed a portrait of him which he intends to include in the series of portraits of celebrities painted by him during the last twenty years, which he proposes to present to the nation. Sir Andrew himself is said to have been so pleased with the picture that, on seeing it in its finished state, he cried out, "Why, it thinks!"—*Brit. Med. Jour.*

The official prospectus of the University of Vienna which has just been issued shows that during the summer semester of 1893 the total number of students in the medical faculty was 2,610. The foreign contingent was chiefly made up of Russians and Americans. The programme for the current winter semester includes 243 courses of lectures, demonstrations, and practical instruction by 23 ordinary and 33 extraordinary professors and by 80 *docenten* and assistants; of these courses, 49 are on internal medicine, 41 on surgery, 34 on gynæcology and diseases of children, 22 on eye diseases, and 17 on dermatology.—*Ex.*

Du Terte, in his "History of the Antilles ("Histoire des Antilles," II, 1667, p. 371) tells how the Caribs, when they become fathers, go to bed. "Then all the old women of the hamlet press around his bed, congratulating the *husband* on his safe delivery." This odd custom was also noticed by an English traveler, Brett, among the Indians of Guiana. "The father," says he, "is put into bed naked, and takes the most indecent postures in his hammock; there he remains several days, as though he were sick, receiving the congratulations of friends, cared for by the neighboring women, while the mother of the new-born child attends to the cooking and does her ordinary household duties.

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OPENING ADDRESS

AT THE SEMI-ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND, AT ANNAPOLIS, MD., NOV. 21, 1893.

BY GEORGE H. ROHÉ, M. D.,
President of the Faculty.

This ancient city and county, so rich in historic associations, are intimately related to the medical profession of Maryland. Almost the first recorded reference to the settlement at Providence on the Severn mentions a certain Dr. Luke Barber, who seems to have been a man of some consequence in the counsels of Gov. Stone and Lord Baltimore.

One of the charter members, and the first president of this Faculty, Dr. Upton Scott, was the chief magistrate of Annapolis nine years before the Declaration of Independence. Even before that time two physicians, Drs. Charles Carroll and Charles Stewart, represented Annapolis and Anne Arundel County in the Legislature. During the revolution, Drs. Charles Alexander Warfield and William Kilty, afterward Chancellor of the State, were prominent among the patriotic defenders of the country. In the troublous times preceding and during the second war with Great Britain, Drs. John T. Schaaff, Reverdy Ghiselin and John Ridgeley rendered services of prominent mention.

Among the charter members of this Faculty were Charles Alexander Warfield, Richard Hopkins, Wilson Waters, Thomas Noble Stockett and William

Murray, of Anne Arundel County, and Upton Scott, James Murray, John Thos. Schaaff and Reverdy Ghiselin, of Annapolis. Dr. John B. Davidge, the founder of the University of Maryland, was a native of this city and an alumnus of its famed institution of classical learning. Other Annapolitans by birth or education who have shed lustre upon the State and medical scholarship are Drs. John D. Godman, William Gibson, John Shaw, Ellis Hughes, Denis Claude, Richard Henry Thomas and William A. Hammond.

This venerable Faculty, soon to celebrate its centennial, finds itself here amid congenial surroundings. Annapolis witnessed its birth, here dwelt its first president, worthily bearing all civic honors bestowed upon him. Here was the home of many of its most distinguished members.

I esteem it a high privilege to preside over its deliberations in this historic chamber, the scene of one of the most impressive and memorable episodes in our country's annals.

The welcome so heartily and eloquently extended by you, sir, was not unexpected. We are not strangers to the fame of Annapolitan hospitality. We came because we knew we should be at home among you, and because we feel at home we reserve the right to tell you that we shall not trespass on your hospitality with our time, and to ask you not to trespass too much on our time with your hospitality.

Much has been said, and well said, at recent meetings of this Faculty, about the advantages of organization. It has been represented as one of the most important duties of the profession. On reading the addresses of my predecessors in the presidential office I felt the subject had been exhaustively and perhaps exhaustingly dealt with. And yet I feel that I should be negligent of my duty if I failed to again bring it to your attention. Consider what a power for good an organized and united profession could be in this State. The organization of county medical societies is the first and most important factor in State union and organization. I am glad to learn that the Medical Society of Anne Arundel County is in such a flourishing condition. Similar societies should be formed in every county of the State, and every member of a county society should be a member of this Faculty. Only in this way can this Faculty properly fulfil its function as a State Society.

At present the physicians of the counties are not largely represented upon the rolls of the Faculty. In past years this was not so. In 1848 there were 669 living members of the Faculty, of whom 462, or more than two-thirds, lived in the counties. This proportion was maintained almost up to 1860. In 1888 only one-eighth of the membership came from the counties, the balance being from Baltimore. Since that time the enrollment of county members has increased so that in 1892 the proportion of county to city members was as 104: 301; or in round numbers, one-fourth of the whole. Our efforts should be directed to restore the relative proportion of county to city members formerly existing. As the county representation increases so will the influence of the Faculty extend. In my opinion nothing will do so much to foster this desirable end as the holding of meetings of

the Faculty in the various counties of the State. We trust many of the physicians of Anne Arundel will take advantage of this opportunity to join our ranks.

A legitimate object of organization is to use it as a power to secure legislation. Not legislation for our benefit as physicians, but legislation for the public good. The medical profession wants nothing for itself from the Legislature. The legislation in which the profession is interested is such as will be for the benefit of the whole people. Public health laws, medical registration laws, lunacy laws, were all intended for the good of the public, although always originated, and their enactment promoted, by the efforts of physicians.

At the last session of the General Assembly, an act was passed creating a Board of Medical Examiners for this State. The Board, or at least that portion of it whose duty it was to look after the qualifications of regular graduates, was elected by this Faculty, and we are bound by the responsibility thus imposed upon this organization to stand by that Board and make its work effective. It has been found by experience that the law as it now stands is defective in certain respects. It fails, I understand, to provide for an official registration of all qualified physicians in the State; it fails to provide for an authoritative verification of the credentials of qualified physicians from other States; it fails to give the Board, or any other authority, the power to revoke permits to practice. These and other defects in the present law should be removed by amendment during the coming session of the Legislature. It is, in my opinion, the duty of the Faculty to assist in every proper way to make this law perfect and then to secure its enforcement. I would suggest that a committee be appointed by the Faculty to render such aid to the Board of Medical Examiners in securing legislation as the latter after consultation might consider desirable.

The exclusion of foreign epidemic diseases, restriction of domestic pestilence, the collection of vital statistics and the progress of sanitary knowledge, are matters of interest to every physician. The incongruityof our general and local quarantine laws,the neglect of States and municipalities to protect themselves or their neighbors against outbreaks of contagious disease, the inefficient systems of registration of vital statistics and the want of some uniform means of diffusion of accurate sanitary knowledge have long attracted the attention of physicians and sanitarians and led to attempts to rectify these shortcomings.

These attempts have heretofore been generally unsuccessful. The National Board of Health of 1879 failed because it was faulty in organization and without appropriate power constitutionally conferred. The quarantine law hastily enacted by the last Congress, largely through the effects of one of our Maryland representatives, the Hon. Isidor Rayner, is confessedly only tentative.

While it has been beneficial in its effects during its brief enforcement, it is not sufficiently comprehensive in its scope to satisfy those who have given thought to such matters. Believing that the time is ripe for securing legislation that will result in the creation of a satisfactory central sanitary authority, the

New York Academy of Medicine has, after long and careful consideration, drown up a bill for the creation of a Bureau of Public Health, which is to be submitted to Congress at the coming session. The main features of the bill will commend themselves to everyone. It takes away no duty or responsibility where these now rest; it merely fixes and specifies them more definitely. It unifies and welds into a harmonious whole all conflicting interests. It escapes the Scylla of centralization without being wrecked on the Charybdis of States' rights. If enacted and carried out in a faithful spirit, it promises to give the country an able, energetic and practical central sanitary authority. I would recommend the appointment of a committe of Faculty to aid committees from other associations in securing the enactment of this much-needed legislation.

But I shall not detain you longer with remarks of my own. The programme before you is full of good meat awaiting your digestion. I invite you to the feast.

ARTIFICIAL VESICO-VAGINAL FISTULA FOR THE EXAMINATION AND TREATMENT OF URETERAL DISEASES.

BY BENNET BERNARD BROWNE, M. D.,
Professor of Diseases of Women in the Woman's Medical College of Baltimore; Member American Gynecological Society, etc.

My attention was first directed to this method of examining the ureters several years ago in a case of vesico-vaginal vistula which I was preparing for operation. The fistulous opening was so close to the orifice of the ureter that I could easily see the urine coming out; by hooking a tenaculum into the vesical mucous membrane the orifice of the ureter was everted so that the urine poured directly into the vagina and a small catheter could be readily passed up the ureter nearly its whole length and the urine drawn off through it.

The method I use in examining the ureters is to place the woman in Sims' position, introduce a broad but short Sims speculum, then with a large steel sound in the bladder, with the point turned toward the vagina, cut down upon it and make an incision from 2 to 2½ inches long, then pass a silver wire 24 inches long from the vagina into the bladder, about ½ inch from the line of incision and bringing it out again on the other side at the same distance from the incision; now pass another similar wire near the other end of the incision; then with a tenaculum pull the loop through from the bladder, then with traction upon the wires open and invert the bladder surface into the vagina; the orifices of the ureters will then be in view, and catheterization and inspection may be readily performed. In many cases in which a morbid condition of the ureters is suspected and almost invariably when such condition is found, there is also a diseased condition of the bladder; so therefore in these cases, instead of closing up the incision, I cut the wires at the loop and bring the vesical and vaginal mucous membranes together, thus keeping the incision open and securing constant drainage from the bladder.

Whether disease of the ureters is secondary to previous disease of the bladder is not a settled question. But I think we can affirm that a diseased condition

of the ureters causing an exfoliation and desquamation of their lining membrane and the decomposition of this in the bladder will surely cause alkaline urine and cystitis. Should the urine become purulent a constant re-infection of the ureters will occur.

When we bear in mind the great propensity that gonorrhœal matter or infection has for following the course of organs lined by columnar or cylindrical epithelium and skipping over or abruptly stopping at those lined by the squamous variety, there is good reason for believing that the ureters, which, according to Kolliker and Luschka, contain a certain amount of cylindrical epethelium, are more frequently affected, primarily, than is the bladder, the disease extending from the urethra to the ureter. Latent gonorrhœal matter or that in the subacute form will travel along the uterus and tubes, skipping entirely the vagina, and stopping at the outer extremities of the tubes where it comes in contact with the serous membrane containing squamous epithelium, unless it is reinforced by some septic material which has a special influence over this variety of epithelium (squamous).

Hart and Barbour, in their excellent work on Gynecology, follow the drawing and description of Holl, which so far as I have seen seems to be the most clear and correct. They describe the ureter in four parts, as follows, viz.:

1. *From the brim of the pelvis to the origin of the uterine from the internal iliac artery.*—About 6-10 inches below the division of the common iliac artery into its external and internal branches, the ureter passes over the external iliac vessels, and lies in front of the internal iliac artery and then in the space between the internal iliac artery and external iliac vein; so far, the portion described is at or about the level of the pelvic brim.

The ureter next passes down into the true pelvis, and at the origin of the obturator, vesical and uterine arteries begins to describe a bow-shaped portion 3.3-5 inches long, with the greater convexity of the bow where the uterine artery crosses it. By this crossing, the bow-shaped portion of the ureter is divided into an upper and a lower part.

2. *From the origin of the uterine artery to where the ureter is crossed by it.* This is the *upper* part of what is known as the bow or spindle-shaped portion.

3. *From where the ureter is crossed by the uterine artery to the bladder.*—The lower part of the spindle-shaped portion. —The uterine artery as it crosses the ureter is separated from it by a venous plexus. In this way a distance of about 2-5 of an inch separates ureter and uterine artery at this point.

At the level of the os uteri externum the uterine artery crosses the ureter to reach the uterus, and at this point the ureter is 3-5 of an inch distant from the cervix. The course of this portion is of great importance. It is 1.6-10 inches long, lies in relation to the side of the vagina, and then for the last 4-5of an inch, before it pierces the bladder, lies between the anterior vaginal wall and the posterior wall of the bladder. The ureter does not pass lower, therefore, than about the middle of the anterior vaginal wall.

4. *The portion piercing the bladder.*—The ureter runs through the bladder wall obliquely downwards and inwards for from 6-10 to 8-10 inches.

The following interesting case, showing some of the effects and symptoms of ureteral disease, was reported by me several years ago (1880) at the annual meeting of the Medical and Chirurgical Faculty of Maryland.

Mrs. M., living in Baltimore County, about 35 years of age, passed bloody urine for more than a year; the blood increased in amount until in some specimens one-half was blood.

At times she had violent attacks of pain on the right side in the direction of the ureter, and colic so severe as to terminate in almost complete collapse.

During these attacks her urine would become perfectly clear and limpid and was passed in larger quantities than usual.

After using such treatment as I thought might palliate her suffering, and failing to obtain any improvement in her condition, on September 4th, 1874, I put her under chloroform and dilated the urethra until my index finger could pass in easily. The upper portion of the bladder was rough and corrugated more particularly on the right side, and in the situation of the right ureter I found an opening nearly large enough to admit the finger. The bladder was considerably enlarged.

A severe hæmorrhage from the bladder came on as the result of my prolonged exploration, which caused me to desist from any further examination at the time. The hæmorrhage ceased in about half an hour, and I left her. In the evening a very profuse hæmorrhage came on and continued at intervals; during the night she passed a large number of what her sister described as similar to hydatids, about one-fourth of an inch in diameter and covered with a skin like a grape.

No further examination of the bladder was made, as the bloody urine gradually became less, and she had no more attacks of pain.

My explanation of the case was that the hæmorrhagic urine was caused by the presence of the hydatids in the right kidney and ureter, which at times blocked up the right ureter, and caused the attack of kidney colic, and this also explained why it was that during these attacks of pain the urine was always clear and limpid, for then the blood was shut off from the right ureter and only the urine from the healthy left ureter entered the bladder.

THE TREATMENT OF ACUTE PNEUMONIA WITH ICE AND SUPPORTING MEASURES.*

BY THOMAS J. MAYS, A. M., M. D.,

Professor of Diseases of the Chest in the Philadelphia Polyclinic and Visiting Physician to the Rush Hospital for Consumption.

Acute pneumonia is a disease which we all well recognize. Its symptoms and physical signs, its course and duration, are constant and characteristic; yet, strange to say, its treatment is as variable and vacillating as its death-roll is long and appalling. In the city of Philadelphia alone fifteen hundred lives are annually sacrificed to this disease. Is this frightful mortality inevitable, or is there a way to escape it? I believe that it can be materially lessened, but before this can be done we must realize the shortcomings and the mischievous ten-

*Read before the Philadelphia County Medical Society, October 25, 1893.

dencies of professional thought on this subject at the present day. I believe that the want of uniformity in the therapeutics of this disease is partly traceable to the prevailing but mistaken theory that pneumonia, like measles and smallpox, is a self-limited disease, an therefore beyond the reach of successful active medication. Then, again, the general skepticism of this age has invaded the field of therapeutics and has cast a gloom of doubt on the remedial effects of the long-honored articles of our materia medica. Both of these tendencies in connection with the fact, which has been shown over and over again, that the practical results of the let-alone treatment of pneumonia are superior to those which are obtained when the disease receives the active routine treatment of days gone by, have brought the therapeutic art into undeserved discredit, and have sown broadcast a belief that the less active the treatment is to which pneumonia is subjected the better it is for the patient. In accordance with this view the disease pursues its natural course in spite of any treatment, and all that can be done is to stand by and watch and treat any incidental danger which may develop.

What ground is there, then, for believing that the pneumonic process is self-limited, and that the therapuetic art is powerless in making a local impression on it? So far as I can see, there is no more reason for regarding pneumonia self-limited than there is for considering any other ordinary acute disease in the same light. All diseases of this kind are limited in duration, but there is no inherent limitation in the same sense, as there is in smallpox or measles. Let us say pneumonia suddenly attacks a single lobe of a lung, and in the course of three or four days it suddenly ends in crisis, and every vestige of the disease disappears. Its sudden onset and termination in many instances lead us to infer that pneumonia is due to the absorption and explosion of a specific poison which exhausts its energy in a few days, and to see an analogy between its behavior and that of smallpox. On the other hand, let us suppose another case of pneumonia involving the same lobe of the lung. In about three days the temperature suddenly drops to within a degree of the normal line, and a favorable termination is anxiously looked for, but instead of this, the temperature rises higher, and on physical examination it is now found that the whole of the adjoining lobe is implicated in the process. A similar succession of events may take place in case another lobe or part of a lobe becomes involved. These phenomena are familiar to every practitioner, and yet can any one say that this is definite proof of the self-limitation of pneumonia? Has anyone ever heard of smallpox or measles attacking the body by piecemeal, first invading one area, then another, and so on? Is it not more probable that the duration of the pneumonic process is chiefly governed by the length of time which it naturally takes for the fibrinous exudation to undergo fatty degeneration? and that when the fibrinous deposit occurs successively in different lung areas the disease will be more protracted on this account than if it confines itself to the area which became primarily involved?

Moreover, it is my firm conviction that the prevailing impression that the

pneumonic process cannot be controlled or restrained by means of active medication rest on an equally insecure foundation. I am not rash enough, however, to assume that any form of treatment can be devised which will always insure against death from pneumonia, but from recent experience I believe that a mortality of 20 per cent., which is the usual death-rate, is too high, and that this may be materially reduced. I also firmly believe that this reduction in the mortality cannot be brought about exclusively through internal medication, feeding, or stimulation, valuable as these measures are. The profession fully realizes the vital importance of sustaining the strength of the patient throughout this disease, and practically this part of the treatment is carried out with very desirable results. Far above the efficacy of all these measures, however, stands ice, or ice-cold water, the local application of which has the undoubted power of subduing and of circumventing the inflammatory process in the lung.

I base this favorable opinion on the results which were brought out in my collective report on "Ice in the Treatment of Acute Pneumonia," which was published in the *Medical News* of June 24, 1893. This paper consists of the condensed histories of fifty cases which were treated locally with ice or cold applications, and which were reported to me by professional friends, or were collected from the literature on the subject, or came under my personal observation. Out of the entire number, two died, making a death-rate of 4 per cent. Additionally I refer to one hundred and six other cases of pneumonia treated in the same way by Dr. Fieandt, a physician of Finland, who had a mortality only of 2.82 per cent.—giving us a death-rate among all of these cases of 3.2 per cent. Moreover, since the appearance of my paper I have succeeded in securing a number of other reports of cases thus treated, which continue to maintain the favorable impression made by the ice treatment in the first report, and which I hope to include in a future contribution on this interesting problem.

Aside from the fact that both of the cases which died among those reported in my list were suffering from probable incurable diseases when they were smitten with pneumonia, and were, perhaps, on this account not the most impartial test for any new remedy, it is quite evident that the total showing is still better than appears on the surface. Great weight must, I think, be laid on the fact that these cases emanate from fourteen independent observers, half of which number report only one case each. This excludes largely the existence of a personal factor—an attribute and a power which grows out of accumulated knowledge and gives its possessor a certain advantage over those less equipped in this direction, and goes far to demonstrate that the curative effects of ice applications do not depend on any very special artistic skill of the medical attendant.

I am often asked whether ice is as efficacious in catarrhal as it is in croupous pneumonia. On theoretic grounds one would be led to believe that it is of greater service in the latter than in the former variety, because the whole inflammatory process is more ephemeral

and entails less organic change in the lungs in that form. While my first cases in which the ice was used were exclusively those of the croupous variety, my later experience has taught me that this measure has a similar beneficial effect in catarrhal pneumonia, provided it is pursuing an acute course. This is fully demonstrated by a number of the cases contained in my report, notably by some of the cases which were treated by Dr. Lees, and also by the one reported by Dr. Franklin. Indeed, I believe it is impossible sometimes to discriminate between croupous and catarrhal pneumonia during life when the latter purses an acute course, and especially when it takes place in infants or small children.

In what special manner should the ice be employed? For want of a better method, the front, side, and back of the affected area are surrounded with ice and wrapped in towels. The number of bags which are needed depends on the size of the area which is involved. If this is small only one or two bags are necessary, but in cases where an extensive area is affected I have applied as many as six and seven, which suffice to cover the whole chest. They are allowed to remain until the temperature becomes nearly normal. Very often it is found that the application of the ice to an affected spot is immediately followed by a marked lowering of the temperature, and improvement in the physical signs in the part. In a very short time, and perhaps in the midst of this amelioration, the temperature rises again, and the patient feels less comfortable than before. Further examination shows that the disease has invaded a new and probably an adjoining territory. Removal of the ice-bags to the fresh spot, or the application of new ones, will again be followed by improvement. This creeping feature of pneumonia must always be borne in mind, and followed up until it ceases.

One difficulty in the use of the ice-bags is to keep them constantly applied to the chest in restless patients, and this has led me to look into the feasibility of making a hollow tin jacket, which adapts itself to the chest, and through which a constant current of ice-cold water may be passed. Such an apparatus I have in contemplation, and when it is perfected I think it will add much to the effectiveness of the application, and will also be a greater convenience to the patient.

The subject of diet demands the most serious consideration of the practitioner, whose aim should be to administer food of the most nourishing character and in the most concentrated and digestible form. In other words, he should strive to give the stomach as little work to do as possible, and at the same time maintain the nutrition of the patient at the highest point. For this reason two ounces of fresh beef-juice pressed out of round steak should be given alternately every hour and a half or two hours, with eight tablespoonfuls of milk, one of whiskey, and one of lime-water. Beef-powder, and nutrient wine of beef-peptone, may also be given.

So far as internal medication is concerned, I would say that strychnine stands first in this respect and should be given unstintedly. Adults should receive 1-25 or 1-20 of a grain twice a day hypodermatically, and 1-25 of a grain by the mouth every four hours,

until there is a manifestation of toxic symptoms, such as an increase of the reflexes, especially of the lower extremities. A quarter of a grain of morphine is to be given subcutaneously in the evening to produce sleep. An ice-bag to the head will also help to allay cerebral excitability and restore quiet. Evacuation of the bowels should be secured by the administration of small doses of colomel and sodium bicarbonate.

When cyanosis and difficult respiration become very marked inhalation of oxygen must be employed. The patient may inhale the gas out of an ordinary-sized rubber gas bag through a suitable mouth-piece which is attached to it. The amount of oxygen which must be given in a case is entirely dependent on the severity of the symptoms, but it is a good rule to push it until the lips and finger-nails assume a more healthy appearance, and the breathing becomes less oppressed, and to give it as often as it is necessary to suppress these symptoms.

Now when we compare the results of the ice treatment of pneumonia with those which are obtained from the prevailing treatment, it will show very much in favor of the former mode of treatment. Thus the mortality of 1012 cases in the Montreal General Hospital was 20 per cent.; while in the Charity Hospital, of New Orleans, it was 20.01 per cent. From 1822 to 1889 the mortality from pneumonia in the Massachusetts General Hospital was 25 per cent. Dr. Hartshorne estimates the death-rate from this disease in the Pennsylvania Hospital, this city, was about 31 per cent. during the years of 1884, 1885, 1886. A comparison of this mortality-rate with that which has been derived from the treatment advocated in the present paper shows that the latter produces results which are at least 75 per cent. better then those which are obtained when the cold applications are not employed. I know that the number of my cases is rather small to draw such promising deductions, but from my experience since they were published I am encouraged to believe that this form of treatment will not only maintain its excellent reputation, but will grow in increased favor on closer acquaintance.

SALICYLATE OF SODA PER RECTUM.

In all cases where salicylate of soda disagrees with the stomach, it can be administered per rectum without any difficulty. In the clinic at Munich, after an evacuating enema, the following mixture is injected pretty high up in the bowel: one and one-half to two drachms of salicylate of soda; water, three ounces, and a pretty large dose of tr. opii to prevent irritation of the bowel.

Newfoundland dogs are to be employed to rescue the persons who fall or throw themselves into the Seine. The dogs are to be housed upon barges anchored in the river. The skill with which these dogs recognize the falling of persons into the river, and the unerring certainty with which they reach the body by the most direct route and seize it at the proper place and swiftly bring it to the barge or shore, are matters of marvel to all observers.—*American Lancet.*

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BALTIMORE, DECEMBER 2, 1893.

Editorial.

THE DECLINE OF PROFESSIONAL ETIQUETTE.

In the recent Harveian oration, the orator, Dr. Pye-Smith, discussed, among other questions, the subject of "professional etiquette," which he defined to mean "the observance of those rules which distinguish a profession from a trade, which make our calling honorable as well as honest, and which check the arts of advertisement and direct our ambitions to obtaining the suffrages, not of the public, which cannot, but of the profession, which can, judge truly." *The Lancet*, in commenting upon these remarks, says, "Pessimists may detect, without the aid of microscopes, not a few departures from these rules, such as advertising in more or less vulgar forms; competition in fees and charges that cannot be dignified with the name of fees; careless or heartless disparagement of the work or character of a professional neighbor; and the tendency to use the style and status of the profession for commercial purposes and for commercial considerations."

For the prevalence of such evils in England, *The Lancet* holds the Royal Colleges and the medical profession to blame "Every week," says this *Journal*, "a device in the way of a handbill or a circular comes to our hand that would be unworthy of a respectable trademan; and not long ago the law courts revealed to us a system by which the wares of limited liability companies were to be pushed by the praise and prescription of medical men whose benevolence had been secured by a present of founder's shares." It is charged that the Royal Colleges have been indolent in the exercise of their disciplinary powers and so allowed the sense of what is professional to almost die out of the minds of those holding their diplomas and subject to their collegiate morals.

Two methods are suggested for the correction of these evils. "The first, and by far the most important, is by raising still higher the standard of preliminary education in those applying to be registered as medical students. It is rare to see well-educated men guilty of those errors of behavior which bring scandal on the profession. Another way in which the leaders of the profession and those in authority in it can maintain its official position is by using their official influence in the Royal Colleges in favor of the more active assertion of their disciplinary powers."

If such a condition of affairs exists in the ranks of the profession in Great Britain, what are we to say in condemnation of such evils in professional practices in our own country? That such

evils exist here, and far greater, no one will question. The competition for position and money has debauched the professional tone in many quarters to that extent that professional dignity has come to mean to many a high-sounding phrase.

The commercial spirit manifests itself in many ways. The overcrowding of the profession with ignorant men is not the greatest of its evils. Such men exercise a narrow influence. They wrong the public far more than the profession. If we look beyond the illiterate practitioner to the man in high position who stoops to low ideals and methods, the sacrifice of professional dignity is more apparent. The eager grasp after priority in original work, the hunger for éclat and notoriety, the break-neck rush for patients and the open grab for enormous fees are a few of the characteristics of not a few modern would-be professional leaders. Show and sensationalism, faultless technique, even in dress, horses, conveyances and office-trapping, are some of the accessories of the commercial practitioner. In his writings, in his talks before medical bodies, in his socials relations, he has but one idea—the dollar. Fortunately such men are rare; but one such man in a community, especially if he be a professor or a society fad, will do more to lower the professional tone than a whole regiment of quacks. When members of the profession are often dazzled by the exploits of such men, what can be expected of the gullible public? Like all fads, such men have their day in all professions. The sensational lawyer, politician, preacher and doctor are products of a sensational age, which applauds the actor today, tomorrow treats him with cold neglect.

Such a character would possess little interest did not his example delude weaker men. They have their imitators by the hundreds and these lesser lights crowd many better men to the wall and often put modesty to shame with boldness and assurance. A few looks through a microscope and a few months of beer-drinking abroad count far more in the estimate of such individuals than years of earnest clinical observation and work.

We do not exaggerate this picture. Such influences exist and they degrade the professional dignity and honor by pretense and by sham methods of work.

Such influences do not correct themselves. In this country we have no Royal Colleges to discipline the profession. Here it is an open course and a free race. Professional self-respect and professional opinion must discountenance and repudiate such men. The personal example of men who stand high in the respect and esteem of the profession will do much towards maintaining the honor and dignity of the profession. The organization of the profession will exercise a similar influence.

The suggestion offered by *The Lancet* is worthy of consideration:

"Every prosperous practitioner, by making himself a little less cheap, a little less accessible to the public, can at once raise his own reputation and diffuse the work which by too much concentration is less well done. There are practitioners who act on these principles; but one can scarcely as yet speak of them as very numerous. We venture to hope that our Royal Colleges will henceforth

exercise themselves not only in enforcing the great morals of practice but in stimulating their diplomates, and especially their Fellows, to consider what they can personally do, by example and unselfishness, to increase that concord of the medical profession which is so essential to its prosperity and its honor. The sister profession of the Law has set us a good example in this respect, and certain recent deliverances of the judges seem to call the authorities of the medical profession to the exercise of more vigilance and activity.

. . .

Apropos to the above subject, we have upon our editorial table at this moment a reprint bearing the title of a prominent professor in a western school. The article in question is so elementary that a first-course medical student or a mere tyro in medicine must be familiar with every idea advanced in this paper. We have reason to know that the offices of many physicians in this city have been flooded with this reprint. This is said by way of illustration. The learned professor is not without learned company. This is only one of the many methods which undermine professional dignity and honor.

Medical Progress.

A TRIBUTE TO THE MEDICAL PROFESSION OF NEW YORK.

At the one hundred and twenty-fifth annual banquet of the Chamber of Commerce, of New York, President Charles S. Smith paid a just tribute to the doctors of the city. President Smith said: "The city of New York and the whole country are under obligations to this Chamber for their prompt action when, a year ago, this country was threatened by an invasion of cholera, and the character which this Chamber has established during the one hundred and twenty-five years of its existence for unselfish devotion to the public welfare enabled it to call upon the public for a subscription to meet a possible emergency, which was responded to in the amount of $195,000, all of which, with the exception of $20,000, was returned to the subscribers. It is also a pleasing duty to acknowledge in this connection the important aid that was rendered to the Chamber by the Advisory Committee of Physicians of the New York Academy of Medicine; and, gentlemen, it is not too much to say that there is no body of men in the city of New York who gave so freely and gratuitously of their time and services to the poor and suffering as do the medical men of New York. If, in the final analysis of human actions, character is the standard of success or failure, then the physicians of New York deserve to wear the laurel wreath."—*Med. Rec.*

INSTANCES OF REMARKABLE FECUNDITY.

When I was a resident medical officer in the Chester General Infirmary I knew an old lady in that city who was notorious as having been confined of twins fifteen times, besides some other single births. Her husband died lately, when his and his widow's lives were noticed in the local newspapers. I think that the old lady is still alive. She, poor soul, under some trying circumstances, lamented her lot—not that she had brought over thirty subjects to Her Majesty, but that thirty of them had not come in triplets, so that she might

have been amenable to Royal bounty. Two other cases of interest in fecundity I met with during my tenure of office. I attended a baby aged three months (who died) whose mother was then eleven years old. It was said that the girl-mother had been subjected to regular intercourse with a grown man, since the age of eight years. As an instance of early conception the case was recorded in one of the medical journals. At Handbridge (just outside the castle walls) I visited a fishwife who was nursing two babies—her own baby and her great-grandchild. The two intermediate generations I saw. The great-grandmother told me that she was sixteen when she was married, which, giving the same age to her daughter and granddaughter for the same events, would but make her forty-eight when I saw her. —J. Lloyd Roberts, in *The Lancet.*

HYDROGEN DIOXIDE AS AN AID IN THE DIAGNOSIS OF SINUSES, PUS-CAVITIES, ETC.

Coplin (*Therap Gaz.*, October, 1893) draws attention to this use of hydrogen dioxide. It is well known that if hydrogen dioxide comes in contact with necrotic tissue, suppurative or otherwise, gas is liberated. If then hydrogen dioxide be injected into a cavity the extent of which it is desirable to know, the gas evolved will accurately map out the extent of the mischief, and in cases in which there is a sinus connecting two suppurating cavities its existence will be readily demonstrated without the need of having recourse to a probe. The author has found it specially valuable in dealing with articular and periarticular mischief. He cites one case in which an abscess had presented itself over the external aspect of the head of the tibia, where it had opened; the abscess cavity communicated with a similar cavity in the head of the tibia. Both cavities were freely curetted, and it did not appear that either communicated with any other, nor was there external evidence of perforation of the cartilaginous disc between the epiphysis and the shaft, save at the point immediately beneath the superficial abscess. On injecting hydrogen dioxide, however, the evolved gas was found to have inflated several points of the subcutaneous tissue; it was further shown conclusively that the joint itself was not involved. The author has obtained equally striking results in other cases and draws attention to this method of diagnosis as one worthy of more extended trial.—*Brit. Med. Jour.*

INFLUENCE OF TOBACCO ON THE SIGHT.

Dowling (*Rec. d'ophthal.*, October, 1892) draws the following conclusions from his investigations: 1. The subjects examined were between the ages of thirty and sixty years, with the exception of one young man of nineteen, and were all workers in tobacco manufactories. 2. In almost all the cases examined there was noted a gradual diminution in the visual acuity of both eyes. 3. The majority of the patients saw better in the semi obscurity of the workshop than in the street. 4. There was color confusion, principally of red and green. 5. The most frequent symptom was contraction of the pupil, and this was most marked in those patients who smoked as well as chewed.—*N. Y. Med. Jour.*

FOR BRONCHIAL AFFECTIONS.

A useful combination in the catarrhal affections of influenza, in cases of ordinary bronchitis, and in cases of broncho-pneumonia due to exposure, especially when there is an associated pleuritis, is the following:

Phenol salicylate or cinchonidine salicylate.	3 to 5 grs.
Terpin hydrate. . .	3 to 5 grs.
Codeine sulphate . .	1-12 to 1-8 gr.

Mix. Dispense in capsule.

Dose: One capsule with water every two to four hours.

This, or a similar prescription, is likewise beneficial in the "colds," bronchitic, pneumonitic, and pleuritic, that often retard recovery or cause "setbacks" in cases of pulmonary tuberculosis improving, or apparently well, under hygienic and other appropriate treatment. In simple pleurisies and in rheumatic pleurisies the terpin hydrate may be omitted.—*Dr. S. Solis-Cohen.*

THE PRESIDENCY OF THE ROYAL COLLEGE OF PHYSICIANS.

There is, of course, much private discussion as to the choice of the successor in the Presidency of the Royal College of Physicians of London to Sir Andrew Clark. No steps have yet been taken in the matter. Among the names canvassed is that of Sir Richard Quain, between whom and Sir Andrew Clark the choice of the College lay on the last occasion, but he will probably not be willing to leave the eminent post of public usefulness which he at present occupies as President of the General Medical Council, unless in response to the practically unanimous desire of the Fellows expressed in some unmistakable manner. Other names mentioned are those of Sir Edward Sieveking, Dr. Wilks, Dr. Russell Reynolds, Sir William Roberts, and Sir George Buchanan. —*Brit. Med. Jour.*

ELECTRIC TREATMENT OF UTERINE FIBROMATA.

Bergonie and Boursier (*Arch. Clin. de Bordeaux*, May, 1893) give a summary of the results obtained by them in the treatment of 100 cases of uterine fibromata by monopolar positive electrolysis, according to the practice of Apostoli. They conclude: (1) That the treatment of uterine fibroids by this method is principally a palliative—efficacious in hæmorrhagic fibroids (90 per cent.); (2) that it acts favorably on the general condition (79 per cent.); (3) that it often diminishes pain (50 per cent.); (4) that as regards the size of the tumors, its action is rarely efficacious (9 to 10 per cent.).—*Brit. Med. Jour.*

OXALIC ACID AS AN EMMENAGOGUE.

Parlet strongly recommends oxalic acid for this purpose. He prescribes:

℞.—Acid oxalic .	gr. xxx.
Infusion of tea . .	f ℥vj.
Syrup of orange-peel .	f ℥ij.

M.—Sig. Tablespoonful every hour.

It is especially at the expected time of the appearance of the menses that this is indicated. Under these conditions it surpassess all the other emmenagogues of the most repute.—*Times and Register.*

"PHYSIC AND PHYSICIANS AS DEPICTED IN PLATO."

The Lancet says: Under this title Dr. Osler delivered an address before the Historical Club of the Johns Hopkins Hospital. The existence of such a club, it appears to us, should fulfil a useful

function. The engrossing cares of the present are somewhat inimical to the antiquarian bias in most instances; but by those who have the time and leisure to study carefully the thoughtful gropings of the human mind in the dawn of science, among many conclusions which later observation must reject, some gems of thought are frequently to be gathered. The interdependence of all human effort is also shown by this lecture, for the material upon which it was based was culled from the memorable work of that ripe scholar lately deceased, Benjamin Jowett, of Balliol College, Oxford. The anatomical and physiological ideas of Plato, based as they largely were on speculation rather than on observation, are essentially Platonic, not Aristotelian, notions, and they enchain us by the brilliancy of imagination rather than by the solidity of their foundation. As another of our American *confrères* has remarked : "The philosophy of Plato is a gorgeous castle in the air ; that of Aristotle a solid structure, laboriously, and with many failures, founded on the solid rock." When, however, we leave the purely physical speculations of Plato and consider his psychology we find that it has, as Dr. Osler remarks, a "strangely modern savor." Nor need this surprise us, for the operations of the human mind were open to observation, subjective and objective, ages before the scientific investigation of the machine which the mind controls. The doctrine of the sound mind and sound body being frequently related to one another was maintained by Plato with eloquence and reason; and in his advocacy of the paramount influence of diet and regimen in the treatment of disease, also in his condemnation of "the purgative method," he would have the approval of many physicians of the present day.

The Platonic method of descending from the general to the particular, of considering the whole when discussing the part, had as a wholesome corollary the regarding of each part of the body as related to the entire system. "Charmides had been complaining of a headache and Critias had asked Socrates to make believe that he could cure him of it. He said that he had a charm which he had learnt, when serving in the army, from one of the physicians of the Thracian King, Zamolxis. This physician had told Socrates that the cure of the part should not be attempted without treatment of the whole, and also that no attempt should be made to cure the body without the soul. . . . The charms to which he referred were fair words, by which temperance was implanted in the soul." The status of the physician in Plato's day seems to have been regulated according as he was a private practitioner or a "State physician," and before he was deemed to be worthy of the latter position it appears to have been essential that he should have been in practice some time and attained a considerable reputation—an eminently rational desideratum not always demanded in the present day. As regards his classification, or what we may term Court precedence, "the physician or lover of gymnastic toils" seems to have been placed fourth, and, it is needless to add, that in the Socratic system the philosopher ranked first. The interpretation given to the dying words of Socrates, "Crito, we owe a cock to Æsculapius," is that thanks are due to

the patron of medicine from one who, by quaffing the fatal draught which robs him of mundane existence, is enabled to realize the glories of hereafter. Dr. Osler pays a warm tribute to Professor Jowett, whom he terms "the great interpreter of Plato to this generation," and, we may add, to generations yet unborn.

INTRA-CRANIAL NEURECTOMY, AND REMOVAL OF THE GASSERIAN GANGLION FOR INTRACTABLE NEURALGIA, WITH REPORT OF CASES.

Dr. Louis McLane Tiffany, of this city, read a paper at the recent meeting of the Southern Surgical and Gynecological Society with this title. Within the past few years intra-cranial excision of portions of the fifth nerve, together with removal more or less complete of the gasserian ganglion, has been done for the cure of intractable trigeminal neuralgia. The credit of first doing such an operation rests with Rose, of London, after whom is to be mentioned Novaro, Horseley, Andrews and others. Dr. Tiffany then gave an account of Hartley's method, which appears in the *Annals of Surgery* for May, 1893.

It has been Dr. Tiffany's fortune to operate four times for excision of intra-cranial portions of the fifth nerve. In each case the reason for the operation was trigeminal neuralgia not due to disease of the brain. Hartley's method was followed. All cases recovered from the operation and were relieved of neuralgia, it is to be hoped, permanently. The operations have been long, but recovery in each instance has been rapid and complete. In all cases, the wounds healed at once, except in the fourth case, where the patient scratched the recent wound and infected it.

It is worthy of note, that in the case of the patient upon whom operation was performed fourteen months ago, there is less anæsthesia and more perverted sensation than in the other cases. Sensation seems to have returned somewhat, and it is interesting to speculate as to whether sensation will ever completely return, and if so, by what route. Preservation of the sense of taste after division of the second and third divisions is to be noted. That the power to recognize heat and cold exists in a region rendered devoid of ordinary sensation by nerve section, is of much interest, and recalls an observation made some time since, that a conjunctiva insensitive from the local application of cocaine still appreciates the difference between heat and cold.

When dividing the third division of the nerve in case four, Dr. Tiffany believes that he isolated and recognized the motor branch before dividing it. Not having provided himself with a sufficiently long and fine electrode, he could not prove the accuracy of his opinion by electric stimulation, and therefore divided everything. By leaving intact the motor branch, the patient would not have food collect in the cheek of the paralyzed side, and in future operations an effort should be made toward this end.

REMOVING ODORS FROM THE HANDS.

A paste of ground mustard and water is a first-rate agent for removing traces of disagreeable smelling substances from the hands, such as salts of valerianic acid, cod liver oil, etc. Huber claims that any oily seeds when

powdered will answer this purpose. The smell of carbolic acid may be removed by rubbing with dampened flaxseed meal.—*Ex.*

TREATMENT OF HYDROCELE.

Neumann (*Fortschr. der Med.*, No. 20, 1893) advocates a method of treating hydrocele which in his hands has been most successful. Under strict antiseptic precautions, a trocar and cannula are inserted; the latter is pushed home, and the fluid having been allowed to escape, the cannula is allowed to remain for two days, the whole being wrapped in cotton wool. After removing the cannula, a cooling lotion is applied, and adhesion of the walls is completed, in seven to nine days, without inflammation or suppuration. Neumann believes that, owing to the presence of the cannula and the altered conditions of pressure produced, a slight exudation of leucocytes takes place, leading to the formation of a fibrino-genous ferment and the occlusion of the sac. The advantages lie in the small amount of time required, the little inconvenience caused, and the certainty of cure.—Theodor (*Achiv f. Kinderheilkunde*, 17, 1-2, 1893) records 36 successive cases of infantile hydrocele which he treated by emptying the sac with a Pravaz syringe, exerting slight pressure on the scrotum and allowing the fluid to escape through the needle. The author then injects two syringefuls of a 1 in 5,000 solution of perchloride of mercury, withdraws the needle, and closes the aperture with plaster. On the next day a slight swelling will be found, but without redness or pains. No recurrence took place in these cases, though in a control series of 36 children previously treated by the older methods, the usual percentages of reappearances were observed. The treatment has the advantage of being painless, always applicable, and apparently the effect of the operation is permanent. The ages of the children varied from two weeks to eight years.—*Brit. Med. Jour.*

RAPID DETECTION OF CHOLERA BACILLI.

In the *Zeitschrift für Hygiene* and the *Zeitschrift für Analytische Chemie* Professor R. Koch describes a suitable method for detecting even single cholera microbes in drinking and river water. Whilst observing the well-known precautions, a small quantity of the suspected water is added to a solution of peptone and allowed to stand at a temperature of 37° C.

If only very few cholera bacilli capable of development are present they increase very remarkably at the above temperature in from six to twelve hours. Owing to their avidity for oxygen they collect upon the surface of the liquid, where, under certain circumstances, they form a fine, though distinctly visible, film. When a drop of the liquid from the surface is examined microscopically the characteristic "comma bacilli" are to be seen in prodigious numbers. In order to be quite certain in the diagnosis, a drop is taken from the surface of the liquid and made up with gelatin (or preferably agar plates) according to the old method. If the gelatin plates are allowed to remain at a temperature of 22° C. (or the agar plates at 37° C.), in from ten to fifteen hours the cholera bacilli, if present, will have grown to characteristic colonies, so that in the most difficult case a demonstration can

be secured in from twenty-one to twenty-seven hours. The occurrence of processes like the above should tend to emphasize the importance of bacteriological examination as a useful, and in some cases a necessary, addition to chemical analysis.—*Lancet.*

A NEW GERMAN.

"My vife leats der fashion this veek alretty," said the German policeman to his friend Reilly, the blacksmith. "Ve had a grade sdade uf affairs at our flat lasd night. She gave a German."

"Is that so?" the blacksmith said, greatly interested. "And whoy was not Oi invited—me and Mrs. Reilly? Oive read of these Germans in the paper over and over again, the curious favors the guest carry away, and all that. Shure, O'im rale sorry yez didn't invite me."

"Yah, dot's so," said the inveterate joker. "Vell, it vos gwide a small bardy vot she gafe, mit only one drophy and only von bardicler frent owdside der family invided. Dot was der doctor. He sayt afdervots it vos von uf der shmallest Germans he ever addended but dot it seemed healthy und he dought it would lif."

VICTIMS TO DUTY.

The Lancet says: "One more name has to be added to the roll of those young members of our profession who have perished on the threshold of a promising career, while actually engaged in the attempt to save the lives of others. We regret so learn that Mr. W. F. Lucas, casualty medical officer to the Middlesex Hospital, died in that institution on Monday last from diphtheria contracted in the discharge of his duties." *The Boston Medical and Surgical Journal* adds this: "Every physician knows many instances where his professional comrades have fallen by his side, struck down by infectious fevers or septic absorption received at the bedside of a patient. Notable instances have recently brought this peril afresh to our minds. A contemporary journal, in the last issue, records the death of a practising physician who caught the infection of yellow-fever from a patient whom he was attending, and also the death of a promising young doctor to whom the infection of typhoid-fever was communicated from a child patient at New York Hospital. Last week it was our melancholy duty to report the death of a brilliant young physician of unusual qualities of mind and heart, who caught diphtheria from a patient at the Boston City Hospital."—*Sanitarian.*

RECENT CORYZA.

℞.—Morphine hydrochlorate . gr. 2
Pulv. acacia 3 2
Bismuth subnitrate . . 3 6
Use as snuff.

A POWDER FOR HYPERIDROSIS.

℞.—Washed sulphur . . . gr. xxx;
Powdered arrowroot . . . ℥iv;
Salicylic acid . . . . gr. vii.
Sig. To be dusted over the feet and between the toes.—*Ex.*

DOCTORS' FEES IN ENGLAND.

English fees have lately been ventilated in the London High Court of Justice (*Med. Stand.*). Dr. Keetley, Senior Surgeon of the West London Hospital, sued Prof. Banister Fletcher for $2,000 for attendance upon the latter's son, who was badly hurt in the terrible railway disaster at Burgos some time ago.

Prof. Fletcher paid $500 in court, declaring that to be an adequate payment for the services rendered. Dr. Keetley testified that he thought $150 a day was a fair remuneration for his undivided attention, even for a day's work in London. He received $75 a day whenever he attended court for an insurance company with which he was connected professionally. Dr. Alfred Cooper testified that, in his opinion, the charges were moderate in the extreme. For himself he should charge $2,000 for a trip to Paris, and $150 or $200 a day while he remained there. For going to Burgos he should charge $5,000. For bringing a patient home from Burgos and taking care of him during a three days' journey, he should charge $2,500. For devoting his whole time to a patient in London, he should not consider $40 an hour an excessive charge. Other surgeons gave similar testimony, and finally the jury decided that Mr. Keetley was entitled to $1,750, a verdict that gave him a substantial victory.—*Canada Lancet.*

HE WAS EXPOSED TO SUCCESS.

Rosevelt—When Blooomstein was in the hospital with us, you remember, we used to consider him stupid. How did he manage to build up such a large and remunerative practice?

Hanneman—He was just shrewd enough to establish himself in a town where the local paper published a column of medical advice each week.—*Puck.*

It is stated that bicycle riding has proved curative in several cases of persistent sciatica.

Medical Items.

Russia contains one physician for each twelve thousand of its population.

Colorada and New York are believed by some to have the best climate for asthmatic patients.

The American Medical Association will meet at San Francisco on the first Tuesday in June, 1894, instead of the first Tuesday in May.

The late Mr. Samuel Farley, of Lordship Road, Stoke Newington, has bequeathed £3,000 each to the East London Hospital for Children and Dispensary for Women, and the Middlesex Hospital.

Dr. A. M. Makejew, professor of Gynæcology and Midwifery in the University of Moscow, has given 100,000 roubles (£10,000) towards the building of a church in the precincts of the new University Clinics.

The Lettsomian Lectures before the Medical Society of London on Peritonitis will be delivered by Mr. Frederick Treves on January 29th, February 12th, and February 26th, and not on the dates previously announced.

Professor Gairdner has been appointed by the Senate of the Glasgow University to fill the vacancy on the General Medical Council caused by the retirement of Professor Leishmann. The appointment is for a period of five years.

Professor Huxley has, at the request of the Rev. Richard Owen, consented to write a final chapter in the forthcom-

ing *Life and Letters of Sir Richard Owen,* which will be an estimate of the work of the great palæontologist.

The Richmond City Hospital has been purchased by the College of Physicians and Surgeons of that city, for eighteen thousand four hundred and eighty-nine dollars and thirty-nine cents.

It is estimated that a modern medical college plant, with facilities for imparting instruction to four hundred matriculates, would require an outlay of one hundred and fifty thousand dollars.

The New Jersey State Board of Medical Examiners have examined one hundred and fifty applicants during the fiscal year just closed, and granted one hundred and fifteen certificates to practice medicine in that State.

The Norwegian Medical Congress which recently convened at Christiania, continued its session on a large steamer which moved from place to place. This new deparature gave change of scene as well as change of subject. The example is commended to our society.

It is said, by one who has had an opportunity of practically testing it, that a wet silk handkerchief thrown over the face affords ample protection against suffocation from smoke. When there is anything to prevent one's making a speedy exit from a house, in case of fire, it is wise to be prepared with this simple device.

The Alumni Association of the Medical Department of the University of Pennsylvania held the first of a series of unique entertainments, called a "Musical Smoke," November 18, at the Colonade Hotel, Philadelphia. The University Glee and Banjo Club furnished the music. There were about two hundred and fifty members present.

According to recent estimates, San Francisco has three hundred and twenty-five thousand inhabitants and an assessed wealth of three hundred millions. In view of this showing the *Pacific Medical Journal* thinks the city ought to have a health department consisting of more than one medical man and six inspectors, and brands this present equipment as niggardly.

Dr. J. W. Middleton, of Steelton, Pa., had his office robbed, and valuable surgical instruments stolen November 13. The thief was caught next day at Midddleton, Pa., having attempted to sell the instruments to some of the physicians of that place. The first to whom the instruments were offered suspected that they were stolen and the telephone did the rest.—*Jour. Amer. Med. Asso.*

The number of cases of smallpox in the country at the present time is considerable. No less than six States have reported cases lately. We recently published the action of the State Board of Health of Pennsylvania in relation to Reading, and the disease is manifestly increasing in Chicago, where the Health Officer announced that there were twenty one cases in the smallpox hospital on November 23.—*Jour. Amer. Med. Asso.*

A method of offering commissions to physicians adopted by a Philadelphia

firm of manufacturers and dealers in trusses is unequivocal. Blotting-pads are sent to all physicians (even oculists!) praising the trusses, the "lady attendant," etc., but the most emphasized part of the advertisement is this, in double caps: "IF YOU WILL SEND US YOUR PATIENTS WE WILL RECIPROCATE WITH A CHECK BY RETURN MAIL." This is a notice to the traders in medicine, but it is also a notice to physicians where *not* to send patients.—*Medical News.*

Munificent legacies for public objects are somewhat rare in France, but Mme. Bouisson, widow of a medical professor at Montpellier, has just bequeathed 1,500,000 francs—500,000 francs for the enlargement of the Faculty of Medicine, 40,000 francs for prizes to medical students, 100,000 francs to Mauguio (her husband's birthplace), 100,000 francs for theological scholarships in the Montpellier diocese, and various sums to asylums and other charities.—*Brit. Med. Jour.*

The Executive Committee of the Eleventh International Medical Congress, Rome, has decided, in its session of the 12th inst., that the Congress, which had been postponed by deliberation of August 2nd, 1893, until April of the following year, shall take place from March 29th, until April 5th, 1894. The Committee has been very glad to be able thus to satisfy the majority of those foreign colleagues, who had been requested to give their opinion on this point. The committee has already taken the necessary measures to secure convenient accommodation at usual prices for the visitors.

In a quiet, decent and respectable manner the Ohio legislature has been petitioned, importuned, and beseeched, year after year, to take cognizance of the quackery that is so rampant in every one of our large towns and cities, but all to no purpose. This year our organized vote at the polls was of such a character and size as to cause a shaking up of political bones in all quarters, and gentlemen who did not have time before the election to come around and say they would, if elected, support a righteous medical practice act, are filing into line beautifully. Their applications and apologies are all accepted with a string attachment, that is supposed to hold them in line during the entire sessions of the next legislature.—*Cin. Lancet-Clinic.*

The American Neurological Association offers a prize of $200 for the best essay on any subject connected with neurological science. This competition is open to physicians who are legal residents of States in North and South America. Essays must be sent to the secretary of the association, Dr. Græme M. Hammond, on or before the first day of May, 1894. Each essay shall be accompanied by a sealed envelope containing the name and address of the author and bearing on the outside a motto, which shall also be inscribed upon the essay. Essays shall be type-written, in either the English or French language, and with the pages securely fastened. The council of the association reserves the right to reject any or all essays judged unworthy of the award. Each essay must exhibit original research, and none will be accepted that has previously been published.

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Original Articles.

SOME FORMS OF NASAL REFLEXES, WITH REPORT OF CASES.

BY S. K. MERRICK, M. D.,

Professor of Nose, Throat and Chest, Diseases of the Baltimore Medical College, etc.

While a few are still sceptical as to the connection between the treatment of intranasal diseases, and the cure of certain so-called reflexes, located in some more or less remote portion of the body, I take it that the great body of medical men, especially among throat specialists, believe the connection to be close.

To mention the names of *all* who have contributed to our fund of knowledge would lead us far beyond the limits of this paper, but it may not be amiss to refer to a few whose labors have thrown special light upon this interesting subject.

Voltilini[1] seems to have been the first writer to bring the question of the nasal reflex to the attention of the profession when he reported a case of spasmodic asthma due to a nasal polypus, cured by removal of the growth.

This observation has since been verified by others.

Seiler,[2] Hack[3] and John N. Mackenzie[4] subsequently published cases of reflex cough, due to morbid conditions within the nasal cavities.

Hack,[5] in his monograph, reports a large number of reflexes; among them are gastralgia, dyspepsia, cardiac palpitation, tumefaction and redness of the skin, of the nose, salivation, neural-

*Read before the Laryngotogical and Rhinological Section of the Pan-American Medical Congress, September, 1893, Washington, D. C.

gia of the first two branches of the trigeminus, cephalalgia, migraine, scotoma, neuralgia, photophobia, vertigo, exophthalmic goitre and others.

Elsberg,[7] Salinger[8] and Bosworth have reported cases of chorea, due to hypertrophic rhinitis. Cases of epilepsy, due to intra-nasal disease, have been reported by Salinger,[10] Fincke[11] and Bosworth,[13] while T. A. McBride reports a case of psychical epilepsy. Ziem[14] reports a case of nocturnal enuresis, while North[15] thinks most cases of neurasthenia will be found to have intra-nasal disease.

Two cases of salivation of reflex origin reported by Bosworth[16] and one by E. Frankel and cited by Rualt[17] and Bosworth, were cured by treatment of intra-nasal conditions, upon which they were dependent.

The question of ocular disturbances, of nasal origin was forcibly brought to the attention of the profession by Dr. Gruenning,[13] of New York, in a paper read before the Academy of Medicine in January, 1886.

Beverly Robinson,[19] Cheatham[20] and Bettman report cases of many forms of eye troubles dependent upon intra-nasal conditions. Many names might be added to those who have reported nasal reflexes affecting divers organs, but the foregoing, in view of their eminence and respectability, are quite sufficient to emphasize the fact that nasal reflexes are not uncommon, nor confined to a very limited portion of the economy.

The moral effect has been invoked to explain the action of treatment in effecting cures. I, however, agree with Bosworth, that while "it may have some force," it is purely secondary and adventitious, in the *great majority of cases,* but in a small per cent. of them I am constrained to believe it is the chief if not the only factor in achieving the result.

He believes that the successful results are due primarily and mainly to the removal of local intra-nasal disease. In this view I cannot fully concur. While this is so in most cases, there remains a small number, which are relieved *before* the morbid condition in the nose is cured and must be explained on the theory of counter-irritation, which was sufficient to excite healthy action in the nerve centres, presiding over the cite of morbid action, *before* it effected a cure at the site of application.

There are three prominent or chief views held, as to just how these reflexes are cured, viz.:

First. By moral influence.

Second. By counter-irritation.

Third. By removal or cure of the morbid causative condition within the nose.

That no *one* of these theories will adequately explain the modus operandi of the curative agent in all cases, I firmly believe; and that all three of them may be necessary to do so, the following cases will, I think, prove.

Case I.—G.S., male, age 28, native of Baltimore; merchant; parents are living and well; one brother died of pulmonary tuberculosis and a sister was suffering with a chronic cough; consulted me November 5th, 1892, complaining of intense headache and vertigo, which had persisted in spite of all remedies for the past six months, until life had become a burden and he feared sometimes he would "lose his mind," if he did not get relief. As his nose had become more or

less obstructed and a sense of pressure over bridge of same was nearly always present, he had concluded that nasal catarrh might have something to do with his distressing headaches and vertigo, and had accordingly come to consult me.

An examination revealed in both nasal fossæ highly inflamed and sensitive turbinates, which were the seat of both false and true hypertrophy.

At the second visit, November 7th, the inferior turbinate on one side was cauterized, and on the 9th he told me his headache and vertigo were much improved. On the 14th, the cautery was again used on the other inferior turbinate, and at his next visit, on the 18th, he told me he was entirely relieved and delighted beyond measure with the result.

Beyond a slight shrinking of the inferior turbinates I could see little improvement in the intra-nasal conditions. The marked relief which my patient had experienced seemed out of all proportion to the slight changes effected within the nose. This, together with the fact that a severe rhinitis was still going on, forced me to the conclusion that the nerve centres, responsible for the head symptoms, had been stimulated into healthy activity by the first cauterization, and that the marked improvement which took place within *two* days could not be due to improvement in the intra-nasal morbid condition, which was not sufficient to be noticed on the closest inspection at that date.

This patient did not return for further treatment, after his head troubles, vertigo and headache were relieved, although his rhinitis was still uncured.

Case II.—A. E. M., male, age 30, native of Pennsylvania, Station Agent Penna. R.R., always been healthy (*family history* not known), consulted me June 15th, 1888. The right nasal fossa was nearly normally patulous, there being slight hypertrophy of inferior turbinate, and chronic rhinitis. The left fossa, however, was nearly completely obstructed by a deflected septum and an exostosis which rose up from the inner side of the floor of the nose half an inch from its anterior opening—the two deformities leaving a small triangular opening for respiration. Both fossæ were in a high state of inflammation and after about two weeks of soothing treatment, I operated on the deflection and a week later upon the exostosis.

The catarrhal process began to improve rapidly after free respiration and drainage were established.

A few days before I was ready to discharge him, he told me one morning, with evident delight, that the cocaine which I had been using in his nose had restored his eyesight. This was the first intimation I had had that he had defective vision, although I had observed that he wore glasses. He had discarded them the night before, finding he could see better without them. I found upon inquiry his was a case of asthenopia of several years' standing. I of course explained to him that the real cause of the restoration of normal and painless vision was the removal of nasal obstruction and cure of his catarrh and that the cocaine played no part in it, except as a local anæsthetic during the operation.

Case III.—Miss L. C. B., single, age 27, born in Montgomery Country, Md. (and lived there all her life), weight 145

pounds, above the medium height. Parents living and healthy; six sisters and three brothers, all strong and healthy.

She was referred to me by Dr. William P. Chunn, of Baltimore, who thought she had some nose and throat trouble which needed attention.

March 1st, 1893, I made an examination of patient's nose and found a badly deflected septum, traumatic in origin. dating from a fall on the ice in girlhood while skating.

The knuckle of deflected cartilage was transverse and firmly adherent to the inferior turbinate of the left side, involving the sutured junction between the bony and cartilaginous septum. The middle turbinate was much hypertrophied and pressing down on the knuckle of deflected cartilage, but not adherent to it. The left nasal fossa was by these deformities almost completely closed. The inferior meatus of the right fossa was completely filled with an inferior hypertrophied turbinate, which on close examination was found tightly bound down to the floor of nose by adhesions, the result of an operation (no doubt) done by a physician in a neighboring Virginia town, just before she had the grip.

Both nasal fossæ were operated on —one with scissors and cautery and the other by means of the *saw* and cautery— and free respiration and drainage were established. Owing to hæmorrhage from the sawing I found it necessary to plug and replug daily for three days the fossa with cotton-wool, and an interesting and instructive feature of the case hangs upon this circumstance, which will be referred to presently.

Twenty-four hours after the cotton tampon was dispensed with, my patient returned to my office, telling me I had cured her of a most serious and distressing eye-trouble of long standing. I then elicited the following history of her case, as nearly as possible in her own words.

Eight years since she began to have headache and the first disturbance of vision. It became impossible to place a book at the proper distance for reading. When she thought it was right it would immediately get wrong. This difficulty increased and seeing double and often triple, with blurring, jumbling and half blotting-out of words, constantly harassed her efforts at reading. By the end of six months, she could not see well enough to paste pictures in a blank book for a child and had to desist on account of imperfect and painful vision.

She then consulted a prominent oculist of Washington, D. C., who gave her three pairs of glasses, which she wore as directed. These made her condition more tolerable and improved the painful vision, until two years since, when she had the grip, followed by measles, when it became necessary to again consult an oculist, who was also a distinguished specialist, of Washington, D. C.

After some treatment of the eyes, the right eye was operated on for slight external strabismus. Vision after this was easier, somewhat, but reading and writing were impossible and vision at all times remained painful and dread of light was always present. She was to return after a month or two and have the other eye operated on for a similar condition, but fell into my hands before the time arrived for her next visit.

I was entirely ignorant of the fore-

going history of her eye troubles, until she related it to me, fours days after I had operated upon her nose.

As long as the cotton tampon remained in the nasal fossa after the operation, no improvement in her vision took place, but six hours after it was removed she suddenly discovered that she could read by gaslight, with perfect comfort, and at once seated herself and wrote a letter to her mother, without glasses, telling her of the "glad news." She had been unable to write for several years. It was the following morning she informed me of the result of the operation upon her eyes. She remained under my care for about two weeks, during which time her vision remained easy and good and I have a letter dated July 29th, 1893 (about four months after the operation), in which she tells me she has just paid a visit to Dr. M., of Washington, D. C., and he frankly admits that my treatment of nose had rendered it unnecessary to operate for strabismus on the other eye, and that there is not the least doubt that the restoration of normal vision was due to the operations which I did on her nose.

Case IV.—J. S., male, age 45, married, engineer, enjoyed good health until six weeks previous, when he was compelled to stop work on account of great pain in right thigh and hip.

Patient consulted me October 12th, 1887; walked with a cane and limped badly. It transpired that he had been relating his case to a neighboring barber who was under the impression that nearly all ailments were caused by catarrh, and insisted that my patient should consult a throat specialist at once. I learned the names of two reputable physicians, who had been treating patient since his trouble began, but no relief was realized. The man had become convinced that all his trouble in leg was dependent upon "nasal catarrh" and that when the latter was cured he would get well of the former. I frankly told him that there was no connection between the two affections.

I found, on examination, a mild chronic rhinitis, most marked in left inferior turbinite, which I told patient I would operate on, and did with gal. caut. Two days later patient returned, walking without a cane and with a very slight limp, saying he began to get better, on leaving my office, at his previous visit. At his next visit he declared himself well, and remained so to this date. No one can convince him that he was not cured by the electro-cautery. I saw little or no change in the intranasal condition, and it is possible that it had no connection with the sciatica, with which the man was suffering on his first visit, but that the case was one similar to that of Bouchard, referred to by Bosworth in his book, Vol. I, p. 197, where a case of sciatica was cured by cauterizing the lobe of the ear.

The description which he gave to the barber of the operation and his feeling during the progress of the same lead me to the conclusion that the "moral influence" was the chief, if not the only factor, in effecting a cure.

This case, however, is reported to invite the opinions of others and some rational explanation of the connection which exists in such cases between the cauterization and the morbid action so remotely situated, and not with the view of expressing any very definite opinion of my own.

The following deductions, I think, may be fairly drawn from the foregoing cases, viz.:

First. That distressing headaches and vertigos, apparently dependent on chronic rhinitis, may yield to intranasal canterization, before the catarrhal process is apparently improved.

Second. That the most serious ocular disturbances may be due to intra nasal disease and that pressure irritation may be the chief factor in such conditions, and that removal of same may yield the most brilliant results.

Third. That pathological processes or symptoms, remotely situated, are occasionally unexpectedly relieved by cauterizing the turbinates.

In the statistical portion of this paper I have quoted freely from Bosworth's book, Diseases of Nose and Throat, but append a bibliographical table for those who wish to consult the original authorities.

843 N. Eutaw Street.

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THE IMPORTANCE OF NURSING AS APPLIED TO THE PRACTICE OF MEDICINE.*

BY J. EDWIN MICHAEL, M. D.,
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Ladies and gentlemen:—I appreciate very highly your invitation to speak to you this evening and had hoped to give you something worth the hearing. But circumstances have hampered me much in the preparation of what I have to say. I have written hurriedly and have not had time to revise, and hence, at the outset, I must beg your kindly indulgence for the defects which will soon be sufficiently apparent to you.

The subject you have selected for me is one in which I am deeply interested and I have only to regret that what I have to present you is neither worthy of it, or you, or myself.

Nursing implies a nurse. What is a nurse? The answer is not so easy to make in such terms as will meet with universal acceptance. Of course we may say, without fear of successful contradiction, what a trained nurse is. A trained nurse is a person, preferably female, who has had hospital experience of a certain amount and has been both theoretrically and practically taught to do all those acts which are implied in the term "nursing" and to leave undone all those acts which are unsuitable in that way. We should, however, err gravely if we should claim that all good nursing is trained nursing. There are those who nurse instinctively and whose services are valuable without special training, or, to be more accurate, who accept instruction readily and carry it out

*Read before the Medical Society of the Woman's Medical College of Baltimore, Dec. 6th, 1893.

intelligently. When, therefore, we come to consider the importance of nursing in connection with practice of medicine, we have not merely to consider trained nursing, but the nursing of any one who can perform the act, whether by reason of regular training or tact and intelligence. Of course we can only expect anything near the ideal perfection of nursing when we have the regular training applied to the naturally intelligent and predisposed person. The functions of the nurse are well spoken of in the plural number. They are several and distinct. The nurse must not only be the physician's hands, but must also be his eyes and ears; and still more, she must perform that herculean task which is so often left undone, viz., protect the patient from the assaults of friends. We must therefore consider the matter from these several points of view.

1. As the physician's hands.—In purely medical cases it is rather rare that the physician himself does more than to carefully examine the case, make his diagnosis, determine upon and order his therapeusis. With the examination and diagnosis, of course, the nurse has little or nothing to do, but the therapeutic measures ordered are her special care. Whether medicines are to be taken, local applications used or baths administered, it is essential that the conditions be strictly adhered to according to order, for in this way only can benefit be expected, and in this way only can the physician judge accurately as to the effect of his remedies. Some remedies are to be given in small quantities and repeated at frequent but regular intervals; some are to be given only whenever certain symptoms manifest themselves. The physician cannot remain constantly with his patient and if he could he probably would not carry out his own orders as well as they would be carried out by a good nurse. Hence the nurse is the medium through which he acts toward the patient. In surgical cases the physican does more and at the same time needs more help, and the nurse comes in for a more prominent portion of the work. Hence in such cases the specially trained nurse is far more desirable than the good untrained one. In ordinary cases in practice the nurse is not usually called on for anything requiring special skill—only care, punctuality and accuracy. In surgery she must know how to do the things which the surgeon requires. To prepare the seat of operation, to provide the dressings, to sponge the wound, it may be, and all this cannot be expected of an untrained person. It is remarkable, however, how well and quickly some women, and even some men, of tact and skill learn what is wanted of them, and assist skilfully. After the operation, thanks to modern methods of operation, as a rule, neither surgeon nor nurse have much to do save make observations and change dressings; cases however do occur in which constant syringings and dressings are required in which the functions of the nurse are of a more purely professional character and require more experience and skill than commonly falls to the lot of the amateur. Obstetrical nursing has about it many things peculiar to itself and hence is not ordinarily undertaken by members of the family. The comparison of merit and utility in this department, therefore, comes not between the intelligent sister, cousin, aunt or mother of the patient and a trained nurse, but between a granny and

a trained nurse. Of course there are grannies and grannies,and I must admit that exceptionally I have seen grannies who have given me eminent satisfaction. But as a rule I regard the granny as not only inefficient, dirty and meddlesome, but as positively dangerous. She is usually filled with her own importance, knows it all, has all the tricks of the trade, but cannot be brought to a wholesome appreciation of the value of clean hands.

If a suggestion is made that she wash her hands, she is apt to be offended, notwithstanding the fact that her sub-ungual inky crescents constantly bear witness against her. The reason why modern obstetricians are able to claim and prove that the safest place for a woman to be confined is a well-conducted lying-in hospital, is simply that the trained nurse is in charge in such institutions, whereas the granny is apt to prevail in the luxurious homes. Hundreds of cases of milk-fever (so-called) and numerous deaths from septic processes have done much to direct attention to these matters,but the world is not yet convinced, practically, that the grannies must go and the trained nurse must take her place. A little more knowledge of these things among the laity, a little more appreciation of the essential difference of results among physicians, some legal restrictions upon the practice of midwifery by ignorant persons, will after a while bring us to a proper state of mind on this question. I do not wish to be understood as advocating any arrangement by which a woman will be compelled to have a doctor and a trained nurse with her when she is confined. Most women cannot afford it. Moreover, a well-trained midwife is all that is wanted in an ordinary case. Let women who wish to practice midwifery have proper instruction and acquire a license by proving their skill, as they do abroad. It is time that some check be placed on the slaughter of innocent women and babes by the gross ignorance and incompetency of a lot of dirty women who are midwives, not because they understood the art and science of obstetrics from the nurse's point of view, but because they have not the ability to earn their livelihood in any other way.

II. As the physician's eyes and ears.—It is too obvious to require argument that the physician is in a better position to treat his patient intelligently and successfully when he has at command a complete detailed history of all the events connected therewith. The supplying of the physician with this very essential information is one of the most important duties of the nurse. The record of a case means a careful and accurate statement of all the events occurring in connection therewith, all the items of which must be set down at the moment of their occurrence. Now, there are two points in this statement the importance of which is apt to be underestimated. They are, the difficulty of obtaining and recording the facts in the order of their occurrence and the almost impossibility of having them related or recorded with quiet, scientific accuracy.

1. Habit is one of the most beneficial as well as one of the most baneful qualities of humanity. A good habit is about as hard to get rid of as a bad one.

This is a central feature in all train-

ing. The individual soldier in a company of veterans is not braver or more intelligent than the average raw recruit in a militia company, but the difference between the two on the battlefield in favor of the former is well known. So the best trained nurse is, as a rule, no more intelligent or conscientious than the mother, sister or wife of the patient, but she is by far her superior, simply by reason of the good habit of recording which she acquired in hospital. If her records were not promptly and accurately made her superior would be on her trail promptly. So in this particular function of the nurse, the one who has had the habit of recording inculcated by long experience has great advantage over the untrained person. Still, just as indisputable courage will manifest itself in those with no military experience, so methodical habit will come, like second nature, to those in whom the capacity to nurse may be, as it were, a latent talent. But be that as it may, if the physician has a nurse, trained or untrained, who can present him, at each visit, a clear, reliable, systematic report of what has transpired since his last, he is in a position to continue his management of the case to the advantage of his patient.

Reflect only on the average struggle for light in a somewhat excitable family with numerous members. The violent struggle between mother and daughter to impress the doctor with the extraordinary events which have occurred in his absence; the frequency of vomiting or purgation, height of the fever, the inward spasms, the intensity of the pains, the yellowness or greenness of the bile ejected, the wonderful twistings and contortions of the patient; and this all intermingled with the views of Aunt Arabella, Uncle Ralph, or the one-eyed granny in the back alley, as to the probable pathology or etiology of the case, and the proper course of treatment to be pursued. And this, like the mechanism of labor, while it must be described separately, occurs simultaneously. The number who speak at the same time is often limited only by the membership of the family.

I have often wondered whether the frequent passage through this sort of ordeal had not something to do with the statistically proved circumstance that medical men, as a rule, are among the shortest lived of humanity. I have really had four women, including the patient, and two men, talk to me so rapidly, simultaneously and irrepressibly that I could only reduce them to comparative silence by firmly closing my eyes and placing my hands over my ears. Compare this with a neatly written account of what has occurred, a glance over which gives you nearly all you want to know, and the clear, succinct answers to a few questions which complete the history.

2. A nurse who assumes charge of a serious case of illness, whether trained or untrained, should be impressed by the fact that the most rigorously exact and conscientious work is required of her in the matter of keeping her record. It is not an interesting or readable production that is wanted, but a concise, accurate statement of facts. Some may deem insistance on this point unnecessary. I suspect they consist mainly of those who have never undertaken to keep a record of an important case as I have. I kept a record in a case which

was of the utmost importance to me personally. It was a case of very grave and nearly fatal illness in my own family. It fully appreciated the importance of a full and accurate account. And yet, when I look over that record now I do not find answers to all the proper questions which might be asked about it. It requires constant and careful attention on the part of the nurse not to omit what appear to be trifles, but what may develop into matters of the first importance.

Our records may be too verbose, but it is a much better fault that they he so, than that they omit essential items. Thus the observations and statements of the nurse, as set forth by her record, give the doctor what his own senses would have given him had he staid all the while by his patient's bedside.

To care for and protect the patient.—So far we have considered the duties of the nurse solely in connection with the physician. She is the medium through which he acts on the patient. She is the medium through which he receives an important share of his information about the progress of the case. These duties are most important, sometimes most difficult, but always definite, systematic and comparatively simple, especially to a trained nurse. The duties directly to the patient are, however, usually more preplexing. The personal equation must come in for much consideration, and all that the nurse has of judgment and tact must be brought to bear.

There are a great many points of analogy between sick people and children and the same rules are of use in their management; for example, firmness must be conjoined with kindness. It must be impressed on the patient by acts rather than words, that the nurse wants to do everything possible for his temporary comfort as well as for his final recovery, but at the same time that the nurse has no time for dealing with unreasonableness and peevishness. And just here is where the difficulty of drawing the line comes. Some sick people seem to think it their solemn duty to keep the nurse going, and this they do equally, whether the nurse be a trained nurse who gets a salary or a loved wife, son, or daughter. Such patients will wait quietly until the nurse has taken a seat after having done some act of kindness, then ask for a drink of water. The water having been procured, and the nurse having again assumed a comfortable position, the room is found to be too hot and a window must be lowered, and so on, *ad infinitum.*

A colleague has related one of his cases to me with reference to this point. He had a fatal disease and had been informed of the fact, yet he made his devoted wife, who was nursing him, get up at night and remove the potted plants from the room, on the ground that their emanations were unwholesome. The circumstance reminds me of the culprit about to be hung who was given a mug of ale as he ascended the steps of the gallows. He blew off the foam before drinking, and remarked, at the same time, that it was said not to be wholesome. When this subject comes up I always think of a circumstance in the life of a venerated relative. He, then a strong man, was ill; not seriously, but enough to confine him to his room, which was in the third story. His wife and son waited upon him most assiduously, both

making many unnecessary trips up and down stairs in his behalf. About the third day, when he was improving, he assumed a most doleful expression and remarked, "I am a healthy man, thank God, and it is not often that I need nursing, but it is very hard that when I am sick I cannot have some little attention." Such patients are, in effect, children, and should be so handled. They should be kindly but firmly taught that there is a limit to the gratifying of useless and inconsiderate demands. This can be done if the nurse is discreet and the family of the patient happens not to be in a state of constitutional idiocy.

I sometimes think it a great pity that visiting the sick is spoken of authoritatively and without modification as a great virtue. The way in which this virtuous act is carried out, generally and especially in the rural districts, makes one of the heaviest burdens the afflicted patient has to bear, and doubtless in many cases increases the danger of the illness, if it does not even occasionally determine a fatal result. Often the worst enemies a sick man has are his friends. There are conditions in which visits from friends are most agreeable and improving. A man on his back with a broken leg is comparatively impregnable to the assaults of friends, but for a poor devil to have to carry on a conversation between the painful coughing spells of a pneumonia or the exquisitely distressing bowel movements of a dysentery is more than can be reasonably expected of human nature. Moreover, laying aside for the moment the simple act of visiting the sick, there is a tendency largely scattered through human nature, as incomprehensible as it is cruel, of keeping the conversation on the illness of the patient, then undergoing torture, and especially of recalling to his or her mind all similar cases known to the visitor in which the results were fatal or otherwise disagreeable. It is the peculiar province of the nurse to look out for these things, and take a firm stand, backed by the doctor, if he be worthy of the name, and either positively forbid the exercise of this scriptural virtue, or restrain it within the reasonable limits necessary for the particular case; if visitors choose to leave cards, with fruits and dainties, and call that visiting the sick, the practice may be freely allowed, but encroachments upon the sick chamber should be closely guarded, and narrowly limited.

Nursing, then, has a most intimate relation to practice of medicine. In fact, there can be no regular and satisfactory practice without it. The more perfectly it is carried out the more successfully can the practitioner pursue his calling. It seems to me therefore that the subject is of so much importance to us as practitioners, leaving out of consideration for the moment the philanthropic aspect of the case, that we as a profession should do all in our power to cultivate it both in families and schools. Trained nurses are, and should be, best, for they spend much time and see much illness in learning. But family nursing is by no means to be despised. Public lectures on nursing should be encouraged in every way. So far as I am personally concerned, I know of no work of my own which has given me more satisfaction or seemed more highly appreciated by my hearers than such lectures on nursing. Time and again I have been thanked most cordially for instruction which had proved serviceable in times of illness and affliction at home.

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BALTIMORE, DECEMBER 9, 1893.

Editorial.

MEDICAL LEGISLATION AT ANNAPOLIS.

At the recent semi-annual meeting of the Medical and Chirurgical Faculty of Maryland a committe of five was appointed to confer with the present State Board of Medical Examiners with a view of having the present State medical law so amended as to make it more efficient and more thorough in its operation. The law as now in force is lacking in many essential features and falls short of the main purposes for which it was intended.

It is not binding upon one who aims to escape its observance, and in a number of instances, we hear, has been evaded. The Board has succeeded in enforcing its provisions to a remarkable degree when the defects of the law are considered. Good work has been accomplished and the influence of the law has been felt.

The committee above referred to has an important duty intrusted to it and it is believed that with its co-operation the Board can secure such amendments to the present law as will make its work more thorough and more authoritative.

Now is the proper time to give consideration to this law. We would, therefore, call attention to the matter and suggest that the profession should give careful consideration to the entire subject of medical legislation in the State and offer such suggestions to the committee or to the Board of Medical Examiners as may seem advisable. An intelligent discussion of this subject in the columns of the JOURNAL will be welcomed by the editor, as he believes the subject is one in which the profession of the State should be interested. We have no doubt that the gentlemen instructed with the duty of securing amendments and modifications of the present law will welcome suggestions as well as assistance in the work which will engage their attention.

It will be no easy task to induce the Legislature to amend the present law. When the time comes it will be found that there are many snakes in the grass. The matter is one of too much importance to handle indifferently. Energetic and prompt action are necessary to success if the profession of the State is desirous of having an efficient and judicious law in operation.

WHAT SHALL WE DO WITH THE CRANKS?

It is quite amusing, as well as refreshing, to observe in the medical and secular press, at the present time, the various theories and suggestions which

prevail in reference to the management of the genus *homo*, known as the "crank." That this individual is almost always of the male sex is worthy of observation. The female crank, if she exists, is usually of such a harmless type that little notice is attached to her eccentricities.

The blood-thirsty crimes committed by the crank upon men of public note invests the acts of this individual with a ferocity which the public mind revolts from with intense emotion. The murder in cold blood of a distinguished public official is shocking in the extreme, yet this form of homicide is being practised almost daily upon men in the obscure walks of life without arousing more than passing notice. The influence of the crank is wide-reaching. Murder is only an extreme form of eccentricity. Arson, theft, destruction of property for revenge and cruelty to all forms of animal life are some of the many phases of crime perpetrated by such individuals.

The method of dealing with this class of criminals is very defective. The law fails to recognize the distinctions which exist between the criminal strictly speaking and the crank. Courts of justice are often controlled by human passion and violent punishment often follows where justice and reason should have exercised the balance of power. Violence is the common expression unless controlled by reflection and clear judgment. The first outbreak of popular indignation would wipe the crank from the face of the earth; the effervescent stage reduces his acts to pardonable eccentricities and permits him to roam at will. Undue harshness or undue laxity are the extremes which measure up the acts of the crank. Hence one will observe in one community that Judge Lynch has passed sentence and in another that His Excellency, the Governor, has granted pardon. Recent discussion has shown many intemperate views as to what should be done with the crank. It is fortunate, however, for weak humanity that scientific investigation has been able to deal intelligently with the problems which distinguish the criminal proper from the crank proper. That there is a difference the intelligent alienist (unless an expert witness for prosecution or defence) will admit. When such individuals are tried by distinguished alienists and not by the courts we may hope to see just and rational punishment for the criminal classes. The judicial murder of a crank creates no terror. It may remove a useless and depraved citizen from being a charge upon the community. But this vindicates no principle of law or justice. It is not only cruel, but it is useless, to murder the crank by forms of law. He is an individual with a pathological brain. His proper home should be under restraint. His right to freedom and to full citizenship have been forfeited by his own infirmities. The State owes him a home and a generous living, he owes the State simple obedience to her restraints.

Medical Progress.

CARBOLIC ACID USED IN FULL STRENGTH IN SURGERY.

Dr. Oscar H. Allis read a paper with the above heading before the Philadelphia Academy of Surgery, Oct. 2nd, as follows:

Surgeons in early days of antiseptic surgery attributed their success to car-

bolic acid. As introduced, it was employed in a dilute aqueous or oleaginous solution. For a time it was the sole antiseptic. To-day it is mainly used in general surgery as a bath for surgical instruments. Few surgeons will demand a reason for its abandonment. Few have not personally experienced its benumbing effects, and have thus been able to assign the collapse following its employment to something different than loss of blood, shock of operation or anæsthetic.

With such an experienee of carbolic acid in its dilute form I confess that I was quite astonished to learn from my friend, Dr. B. F. Gardner, of Bloomsburg, that he was in the habit of using the article in its full strength upon extensive cut surfaces, and that, too, with the happiest results. As this article owes its entire value to Dr. Gardner, I will give in detail his method.

When Lister introduced his paste, Dr. Gardner used it quite extensively. After an application to quite an extensive wound surface he was surprised to find it turn white, and that he had used pure carbolic acid. He therefore immediately washed the surface and dressed the wound, keeping it open until oozing had ceased. The case did so well that it inaugurated with him a line of treatment that he has extensively employed. As a typical application let me take an amputation of the female breast. After its removal and the ligation of the bleeding vessels, carbolic acid crystals, dissolved in sufficient water for solution, are applied with a sponge to all parts of the cut surface. Immediately upon the application of the acid the tissues turn white, which is a guarantee of its thorough action. The wound surface is then washed with water previously sterilized by boiling, and then approximated with provisions for drainage. This is especially necessary, as for twenty-four hours the oozing must find ready exit. During the first few days there is a slight local hyperemia along the borders of approximation, but this declines without crisis.

Dr. Gardner claims for carbolic acid applied in officinal strength:

1. That no systemic absorption attends its use, and hence no danger, no shock.

2. That it is a local anæsthetic. Hence there is not as much pain after the operation.

3. That it is in a measure a hæmostatic acting especially upon the capillary vessels.

I have taken the removal of the mamma only as an illustrative case. In all operations outside of the pleuritic and abdominal cavities, such as amputations and resections, Dr. Gardner resorts to it.

In hydrocele he lays open the sac freely, then applies carbolic acid to the tunica vaginalis, and concludes with packing or drainage. The operation is not followed by excess of any kind, and recovery is prompt. He has used it in gunshot wounds of the knee and ankle. If he gets such a case after suppuration has set in he freely opens the joint, applies the carbolic acid to every part, washes out all excess freely, secures ample drainage with fixation, and confidently awaits the result. Anchylosis may follow, but this will depend on the extent of the injury, the delay in treatment, the conduct of the patient. Dr. Gardner has used bichloride of mercury,

hydrogen peroxide, iodoform, etc.; none of them has answered the claims made for them; all have disappointed him, but pure carbolic acid *never*.

I have said that Dr. Gardner does not use this upon serous membranes, *i. e.*, within the abdomen. I must modify this statement. In a case of strangulated hernia, in which he found patches of sphacelus—not deep, but threatening—he cautiously applied the pure acid and returned the gut. Fortunately, the strangulation had been arrested by operation in time to save the gut. Nothing eventful in the subsequent history, which was speedy.

I do not know Dr. Gardner's theory of the actions of this powerful drug, and shall attempt no explanation. The turning of the wound surface white is due probably to the coagulation of the albumin of the tissues and fluids of the wound surface, and not that the acid has a necrotic effect. That it does not produce a true destruction of tissue may be inferred that after a large breast or thigh amputation he will have primary union and no suppuration. In its use in hydrocele a half drachm or more is injected into the tunica vaginalis, and resolution without suppuration ensues. It is possible that by its action upon the wound surface an action similar to that obtained by heat may be produced, and thus facilitate repair.

I will conclude this article by briefly stating my own experience with it.

On entering the wards of the Presbyterian Hospital I found that one of my amputations of the thigh had not done well, and looking at the stump found it swollen and of an angry, threatening character. The seam of approximation was perfect. I therefore removed all the sutures, and separating the flaps found them almost in a stage of gangrene. Taking carbolic acid pure, I applied it freely, pressing it into the tissues with the sponge applicator, removed the excess, and, packing the space between the flaps, renewed the dressing. This was done without anæsthetic and without apparent pain. The exposed surfaces soon began to granulate, when they were approximated and recovery soon followed. I have also frequently applied it upon a carrier with cotton to sinuses and after curetting glands.

LEAVE THE CODE AS IT IS.

The *Medical News* finds it necessary to say a few more words on the Code question in order to make its position clear. We still believe the course outlined by us in various editorials, and especially in the issues of September 17, 1892, and January 28, 1893, to be the best possible permanent solution of the Code question.

Realizing, however, that under existing circumstances this course cannot be successfully entered upon, we now announce ourselves as definitively against revision. We prefer the Code as it is to any amendment suggested publicly or privately, officially or unoffically, that seems to have any prospect of passing.

Except in one particular, the Code does not interfere with the comfort, prosperity, or freedom of any *honest and honorable* physician—for no such physician desires to do anything the Code inhibits. In the one particular referred to—namely consultations with sectarians and quacks—the few honest physicians

who find the Code opposed to their sincere judgment, must yield to the will—the just and proper will—of the majority. For reasons unnecessary to repeat, that prohibition must be maintained. There is no discussion of the Code that has not been aroused by its opponents, and if these will cease their unwise agitation there will be nothing to interfere with scientific business at the meeting of the American Medical Association. Let our united efforts, then, be made on behalf of the honor and dignity of the profession as represented in "the Code as it is."—*Med. News.*

CYSTITIS.

Dr. C. O. Stockton says, in *Med. News:* In the treatment of cystitis not only must the urine be kept neutral, but it must also be kept diluted, and hence bland. Large amounts of absolutely pure water, distilled, or rain-water, must be used. Mucilaginous drinks also have some curious influence to make the urine bland. The mucilage itself, of course, does not pass out with the urine, but probably some constituent of the mucilage does. Balsamic preparations also render the urine bland. The oil of sandalwood is perhaps as useful as any. It may be given in capsule, gtt. v-x every four hours, until the urine is moderately impregnated. Improvement likewise follows the use of less balsamic diuretics, such as buchu and uva ursi. Fluid extract of buchu, fifteen minims (one cubic centimeter), every two or three hours during the day and perhaps once during the night, acts as well as any of this class.

The remaining treatment of cystitis is local; this means washing out the bladder. A clean catheter is used; the urine is first drawn off, then the bladder is washed with distilled water so as to remove shreds of epithelium and mucus. Following this, astringents, stimulants, or sedatives may be used according to the indications of the case. I was an interne in this hospital when the local treatment of cystitis was first talked about in this country. I well remember seeing patients lie here month after month without any attempt at local treatment, and I remember one boy whose bladder I had to wash out every day, and I looked upon this treatment as a hardship and as quite heroic. This patient had a gonorrheal cystitis, and he became worse under treatment as the bladder was washed out with a strong astringent solution. At the time I condemned the method of treatment, but now I have no doubt that, if milder solutions or even distilled water had been used, the patient would have recovered under this treatment. He improved somewhat after the washing out of the bladder was discontinued, but he did not entirely recover.

One of the best preparations to use in washing out the bladder is boric acid, making a saturated solution in cold water, then heating the water to about the temperature of the blood and introducing it gradually. If the solution is allowed to run in quickly, it will induce a spasm of the bladder. The next day after this treatment a solution of hydrogen dioxid (25 per cent. of the fifteen-volume solution) may be used. The balsams may be suspended in water by the aid of magnesia and introduced after filtration. I do not know exactly how to state the strength of the solution. I usually pre-

pare it by rubbing up a dram of oil of sandalwood with magnesia, putting this on a filter-paper, and passing through it a pint of distilled water. Just how much of the sandalwood remains in solution I do not know.

One other important point in the treatment of cystitis is rest in bed. This girl was walking about the ward when I took charge of her, and passing water every half-hour. She now rests in bed and passes water every two or three hours. The diet should be perfectly bland. Milk is often the best food, but it sometimes causes fermentation in the stomach and upsets the system. Vegetable and starchy foods are usually admissible, but little or no meat should be given. Coffee and tea, as well as all condiments, spices, and salt, should be excluded. One often goes astray in thinking that milk diet should always be used in such cases.

CALOMEL IN THE TREATMENT OF GOUT.

Dr. Grimm (*Deutsche Med. Wochenschrift*) says:

Fourteen years since I began the use of calomel in acute and sub-acute articular gout and the immediate sequelæ, with most satisfactory results. In more than twenty cases where employed, it acted as a specific. In a number of other cases it afforded immediate relief from suffering, its action being succeeded by slower recovery. I ascribed its value to its power to incite active peristalsis, since in robust subjects an attack of gout is usually preceded by sluggishness of the bowels, and it is in such cases the best results are obtained. It must be given so that active peristalsis will result from the very first dose. One thorough emptying of the bowels is generally sufficient to inaugrate improvement, and likewise to continue it. Prolonged treatment is rarely indicated. After the calomel a carminative may be prescribed if desired.

I have also employed the yellow oxide of mercury in gout, which appears to act even more energetically than the submuriate.—*Medical Age.*

THE TREATMENT OF PRURITUS.

Dr. E. B. Bronson, of New York, read a paper on this subject at the recent meeting of the American Dermatological Society.

The chief underlying condition in pruritus is hyperæsthesia, whether in its common significance of an excessive irritability of the sensory nerves, or in the sense of an excess or engorgement of sensation. The prime indications, then, are to allay irritability and to divert or annul the excess of nervous excitement. Measures to remove local excitants include, first of all, such as directly tend to prevent scratching. To admonish the patient to refrain from this is usually of little avail. Restraint may be possible during waking hours, but at night, when the trouble is always at its worst, and especially during the state of somnolence midway between sleeping and waking, no power can prevent it. It can only be avoided by first mitigating the lesion through the aid of antipruritics. Sedatives when used internally are apt to be disappointing. The degree of general sedation that is required to affect the nerves of the skin in so intense a disturbance as pruritus often is, affords a sufficient reason why this method of treatment is usually objectionable. Further than this, the depressing and atonic after-effect on the nervous

system tends to exaggerate the general hyperæsthesia which is already essentially an atonic condition, and thereby increases the tendency to itching. Especially objectionable are most of the narcotics. The bromides, on the other hand, are often indispensable, and may be required in liberal doses. It is important to avoid the enervating effects of loss of sleep, and for this purpose sulphonal or some other hypnotic is occasionally needed. In connection with this, two internal remedies, which have been especially recommended by Bulkley, are worthy of mention, and they are cannabis indica and gelsemium. The former is known to be a cutaneous anæsthetic as well as an analgesic, and by virtue of the former quality should be useful in pruritus.

Carbolic acid is the most reliable and most generally useful antipruritic which dermatologists possess. It was well named by Unna "the opium of the skin."

ON THE TREATMENT OF MALARIA AND DIPTHERIA BY METHYLENE BLUE.

In thirty cases of malaria with intolerance for quinine, the author has obtained good results by the internal employment of methylene blue. The conditions of the cases are that there were no counter-indications against its use, such as nausea, vomiting or polyuria.

It need not be given in very large doses; for example, .30 grams two or three times per day. It should be associated with pv. myristica to prevent the appearance of hematuria. The doses of .50 grams per day for adults and 25 to .40 grams for children of four to eight years of age, suffices to obtain an action against the attack of malaria. Methylene blue does not prevent new attacks, but renders them less intense, the same as other anti malarial remedies.

In fourteen cases of diphtheria, the author has obtained notable amelioration from painting with methylene blue of 10 per cent. solution in water. This substance, he states, is preferred to chromic acid, carbolic acid water, chlorid of zinc or sublimate, because it is not irritating to healthy tissues.

In saturating the false membranes, it probably prevents the secretion of toxic substances, and opposes itself to the propagation of the bacilli.

Ferreira, in *Bulletin General de Therapeutique*, gives twenty-one observations of infantile malaria treated with methylene blue. He concludes that methylene blue merits large employment in infantile malaria.—A. N. Kazem Bek in *Revue des Sciences Medicales*.—From *Vratch*.

THE TREATMENT OF DIPHTHERIA.

An excellent *resume* of our knowledge of the bacteriology of diphtheria is given in the *Semaine Medicale* of Sept. 30th by Dr. Veillon. He assumes that it is now generally accepted as proved that the bacillus first described by Klebs and Löffler is the main causal agent of diphtheria, although other organisms, such as the streptococcus and staphylococcus pyogenes and one resembling morphologically the pneumococcus, are frequently to be found together with the pathogenic bacillus. As a result of his investigations Dr. Veillon maintains that the treatment must necessarily be complicated, for we have to

deal not only with the local effects of the Klebs-Löffler bacillus, but also with the constitutional effects produced by the toxines evolved, and the lesions produced by secondary infections. Various antiseptic agents have been proposed in order to destroy the germ—corrosive sublimate, phenic acid, &c. The most successful seems to have been the first mentioned. Great difficulty has always been found in reaching the parasite, as it is protected by the false membrane. Dr. Veillon recommends removal of the pseudo-membrane by curved forceps having cotton-wool wrapped around the points. If, however, this should produce much bleeding he would advise sprays and irrigations only. The applications should be made to the throat very frequently—at least every hour. With regard to the second point—namely, to combat as far as possible the toxic effects—Dr. Veillon is of opinion that swabbing the throat and frequent irrigations are of great value; the poison is soluble in water, and much of it may be thus swept away. Observers have pointed out that the toxines are less active in an acid medium; therefore dilute acids, such as lactic and tartaric, may also be used as sprays. Dr. Veillon suggests a saturated solution of boric acid, to which 1 per cent. of lactic acid is added. Our present knowledge helps us but little with regard to neutralising the toxine already absorbed. The numerous laboratory experiments which are now being made by Behring, Kitasato and Martin may eventually bring about the desired end. A method of attenuating the diphtheritic virus seem to have been successfully accomplished by the first two observers named above, but the investigators have not arrived at that stage when it may be applied to man. Preventive inoculation would seem destined to hold a vastly more important place in the therapeutics of the future than it does at present, but some time must yet elapse before the much-wished-for methods can be definitely formulated.—*Lancet.*

THE ANNUAL REPORT OF THE SURGEON GENERAL OF THE ARMY.

The promptitude with which the surgeon general of the army prepares his annual report seems to be equaled by that of its printing and distribution, for within a fewmonths after the termination of the fiscal year the public is in possession of the achievements of that year. The total expenses were $104,538.80, although an additional expenditure of some $65,000 will be made for supplies ordered previous to July 1, 1893, thus making a total of about $170,000. This sum does not include the salaries of the medical officers or the money expended for the services of contract surgeons.

Over a thousand specimens were added to the museum, and more than eight thousand books and pamphlets were placed in the library.

Of forty-three candidates examined for admission into the medical corps, twenty were rejected for professional incapacity, seven were rejected for physical disability, four withdrew after partial examination, and twelve were found qualified. These figures are of considerable interest because they indicate either that a better class of men are taking the government examination or that the medical colleges are giving more thorough instruction, for the percentage of candidates that pass is higher than in former years.—*N. Y. Med. Jour.*

Medical Items.

A statue of Ricord, says *L'Union Medicale*, has been erected in front of the Hôpital du Midi on a pedestal that has already been some time in place.

Polly Thompson, generally supposed to be Queen Victoria's oldest subject, died on November 13th at the Camberwell workhouse, in her 107th year.

It is understood that Sir Joseph Lister will be elected to succeed Sir Archibald Geikie in the Foreign Secretaryship of the Royal Society. His claims to that distinction are unique.

During the past year 1,652 persons bitten by rabid animals have been under treatment in the seven Pasteur stations existing in Russia. Of these, 42 have died of hydrophobia.

On the authority of the *Homburger Freisinnige Zeitung*, there were in Prussia, in one year, 1,200 individuals who died from delirium tremens, and 500 who committed sucide thorough intemperance.

The house and splendidly equipped laboratory of Dr. E. L. Truedau, at his sanitarium at Saranac Lake, New York, were detroyed by fire December 4th, during Dr. Truedau's absence in New York, where he is seriousily ill.

The Alumni Association of the College of Physicians and Surgeons of New York offers a prize of $500 for the best essay embodying the results of original investigations upon any medical subject. Essays must be sent to the Secretary before April 23rd, 1894.

The *Hot Springs Med. Jour.* says that the City Council of that enterprising resort has enacted that hereafter the drummers who solict patronage for the local physicians must be duly labeled according to law, and wear a numbered tag.

The chair of pædiatrics in the University of Berlin, made vacant by the resignation of Professor Henoch, was offered to Dr. Abram Jacobi, of New York, who has declined the honor, preferring to remain an American citizen. This is the first time such a distinction has been offerred to an Americon physician.

A member of the Anthropological Society of Washington, D. C., has offerred two prizes—one of $150 and one of $75—for the best essays on the subject of "The Elements that go to Make up the Most Useful Citizen of the United States, regardless of Occupation." The essays, to be of 3,000 words, must be sent to the Secretary of the Society by March 1, 1894.

The officers of the Montgomery County Medical Society elected for the ensuing year at the meeting on November 28th are as follows: President, Dr. Roger Brooke; First Vice-President, Dr. Edw. Anderson; Second Vice President, Dr. J. H. Deets; Secretary, Dr. Otis M. Linthicum; Treasurer, Dr. E. E. Stonestreet. Dr. Stonestreet, the retiring President, delivered the annual address.

At the recent meeting of the Southern Surgical and Gynecological Association the following officers for the ensuing year were elected: President, Dr. Cornelius Kollock, of Cheraw, S. C.; Vice Presidents, Dr. A. B. Miles, of New Orleans, and Dr. J. B. S. Holmes, of Rome, Ga.; Secretary, Dr. W. E. B. Davis, of Birmingham, Ala.; Treasurer, Dr. H. P. Cochrane, of Franklin, Tenn. The association adjourned to meet in Charleston, S. C., on the third Tuesday in November, 1894.

The will of Sir William Jenner's brother, the late Mr. Charles Jenner, of Edinburgh, benefits an unusually large number of celebrities. It gives £3,000 to Sir William and £7,000 to his children, £2,000 to Mr. Thomas Woolner, R. A. (now deceased), £2,000 to Dr. William Smith, the transalator of *Fichte*, etc., £4,000 to his two daughters, £200 to Mr. David Patrick, editor of *Chamber's Encyclopedia*, £1,000 to Sheriff Campbell Smith, of Dundee, and £3,000 with an annuity of £50 to his daughter.

The medical society of the city of Hartford, organized in 1846, is to receive a fund for the erection of a building to be devoted to its purpose and to those of the medical profession of that city. It will be in memory of the late Dr. Ebenezer Kingsbury Hunt, formerly president of the Connecticut State Medical Society, in the compliance with the terms of a bequest of the late Mrs. Mary C. Hunt, of Hartford, widow of the late Dr. Hunt. The medical school at Yale University will also fall heir to the sum of $25,000 under the will of Mrs. Hunt.

There appears to be one European country at least where the medical profession is not overstocked. In 1892 the total number of medical practitioners in Hungary was 4,047, of whom 3,556 were Doctors of Medicine and 491 surgeons. This gives a proportion of practitioners to population of 2.66 per 1,000. In Austria the corresponding ratio is 3.16 and in Germany 4.15 per 1,000. The midwives in Hungary number 7,570, which is hardly up to the requirements of the population. There are 1,186 pharmaceutical establishments, being 1 to 12,418 inhabitants and 2,289 square kilometres. The death-rate averages 7.15 per cent. The total number of deaths in 1892 was 500,439.

The Grand Duke Karl Theodore, heir presumptive to the Palatinate of Bavaria, is the director of two eye-hospitals, one at Munich and one at Meran, in the mountains, to the south of the capital. He does a goodly amount of eye work among the poor. He takes no fees, but a box at the door of the consultation room has been arranged to receive voluntary contributions. He has now the help of his eldest daughter, the Duchess Sophia, as his chief assistant, They both begin the day's work at 7 o'clock in the morning. The Hospital in the mountains has the preference with the Surgeon, for there he gets the better results after operations; he spends the larger part of his time at Meran.

The Czar of Russia recently issued a ukase on medical fees which divides the population into three separate classes; the first one composed of the nobles, the capitalists, the landowners, the manufacturers, the bankers, the merchants and

members of the first six classes of the civil, military and naval service. The second class comprises lawyers, parsons, and professional men of one kind and another, as well as government employes of the seventh and eighth grades; while class number three is of the remainder of the population. For patients of first class the fee is limited under severe penalties to $2.75 for each consultation; for those of the second class to $1.65; while the cost of medicall advice to the masses is limited to 19 cents.

The *British Medical Journal*, owned and published by the British Medical Association, has reached a position of great prosperity. A recent report states that the weekly issue now reaches 17,850 copies, a gain of 500 copies annually in the last twenty-eight years. Mr. Ernest Hart's visit to this country has opened up a new field of enterprise for this journal. The journal says, "Henceforth America will play a larger part in our visions of scientific, social and administrative developments. For undoubtedly many important problems in practice and teaching are being worked out in the States. We have made arrangments for a much fuller representation of the doings and thoughts and the best aspirations of the American profession in our columns than has been before possible."

Among the members of the medical profession in foreign countries who have recently passed away are Dr. C. E. Figuière, a prominent practitioner of Geneva, for many years a member and sometime President of the Municipal Council of that city, aged 79; Dr. Woldemar Poorten, of Riga, well known as a specialist in ear diseases, aged 60; Dr. Carl Johansen, one of the oldest and most eminent practitioners in St. Petersburg, and for 28 years Director of the Municipal Hospital of SS. Peter and Paul in that city, aged 78; Dr. Peter Kraszewski, Director of the "Kindlein Jesu" Hospital of Warsaw, aged 55; Professor Rudolf Kaltenbach, head of the Gynæcological Clinic in the University of Halle; Dr. Hermann A. Hagen, Professor of Entomology in the University of Harvard, and formerly First Assistant in the Surgical Clinic at Konigsberg, aged 76; and Professor Eugenio Ribera, Dean of the Medical Faculty of the University of Cadiz.—*British Med. Jour.*

On the evening of December 2nd a destructive fire broke out in a large warehouse on South Paca Street, in this city. Before the fire was arrested the flames extended to Practice Hall, on the grounds of the University of Maryland, and completely destroyed this building. The building had but recently been rebuilt and enlarged by the Faculty of the University and contained probably the best equipped laboratories and dissecting rooms in the city. The fire also extended to the old University building, but was arrested before serious damage was done to the classical old building, so familiar to many physicians. The loss to the Faculty by the fire was quite a serious one, but we are glad to announce that there has been no interruption in the work of the University. Arrangements were at once made for laboratory work and the students have lost no time by reason of the fire. We understand the destroyed property will be rebuilt at an early day.

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Original Articles.

THE EARLY DIAGNOSIS OF TYPHOID FEVER.*

BY WM. F. LOCKWOOD, M. D.,
OF BALTIMORE.

Since the recognition of typhoid fever as a distinct disease, a question finally settled to the satisfaction of clinical observers and pathologists throughout the civilized world about 1850, medical journals have abounded in contributions to its literature, and text-books have appeared in quick succession which have discussed systematically and exhaustively its history, its pathology, its diagnosis and its treatment.

Without wishing to recount the symptoms whose development and sequence are perfectly familar to you all and without claiming to have discovered any pathognomonic sign, I have decided to read a very short paper this evening upon the early diagnosis of typhoid fever. I do so with less hesitation than I should otherwise feel in selecting a subject which it would seem has been already set forth with all possible clearness, for the reason that during the last few years this subject has greatly interested me and because in common with every general practitioner of medicine I have experienced the embarassment of long deferred diagnosis. The conviction that much can be gained by the prompt adoption of the bath treatment in suitable cases of this disease must stimulate the physician to decide more boldly on the nature of the malady with which he is

*Read at the meeting of the Clinical Society of Maryland, Nov. 17, 1893.

dealing and to give his patient the best chance for a satisfactory termination of his illness. Until comparatively lately the general rules of rest in bed and liquid diet, applicable to all cases of continued fever, have usually been deemed sufficient to fulfil all the requirements of prudence, and the diagnosis has been made as a rule, with great deliberation, at any time during the first or second week of illness.

So deeply marked has been the impression created by text-books and by the teaching of clinical instructors that the characteristic signs of typhoid fever would only gradually unfold themselves, that until within the last few years I do not remember to have attempted making a positive diagnosis of this disease at the first or second examination of a patient unless his illness was already well advanced. The history of malaise, the headache, the epistaxis, the iliac gurgling, the diarrhœa, the tympany and abdominal pain, the cough, the rose spots, or such of them as might occur, had all to be taken into account before arriving at a definite conclusion. But notably the temperature chart was to be carefully constructed, which should show a gradual rise of fever during the first week, a stationary period in the second and a decline in the third.

As to the chief symptoms in typhoid fever there can be no diversity of opinion, nor will any one dispute the fact that some cases of this disease run their own course with little regard to the text-book description of typical cases. In a small proportion of cases the best that can be done in the matter of diagnosis is to bide one's time and to watch cautiously for some distinctive symptom. But in a second and much larger proportion of cases the diagnosis can be made with reasonable certainty at the time of the physician's first or second visit, or within twenty-four or forty-eight hours from the time the sufferer feels sick enough to seek medical advice. It is with reference to this second class of cases that I wish particularly to speak, believing that many of us have dawdled unnecessarily over our diagnosis of them.

The onset in these is practically sudden, the student continuing his work and the clerk attending to his business until immediately before the physician's visit. Frequently the patient is seen first at the physician's office, and disclaims any idea of remaining indoors the next day, or of his being sick enough to interrupt his business or pleasure. He admits that he has not felt well for a day or two, and while he complains of severe headache, his manner is nervous and restless, and differs in its alertness from the subdued, depressed manner of ordinary headache. His eyes are unusually bright, the conjunctivæ slightly injected, the cheeks commonly flushed. There is probably a marked erythematous blush over the sides of the neck, and front of the chest. Without having had a decided chill, there have been chilly or creepy sensations. Stiffness of the neck is usually associated with occipital pain, and with spinal stiffness and soreness. Slight griping pains have probably been felt in the abdomen irrespectively of any imprudence in diet. The pulse may be but little quicker than normal, and as a rule is irritable and jerky. The temperature is raised to 102° or even 104° if the patient has been moving

about actively. Slight nose bleed is apt to have occurred even as early as the first or second day. Taken collectively, these symptoms point almost unmistakably to typhoid fever. The *tout ensemble* is strongly suggestive of that disease, even if not absolutely convincing. No single early symptom can be relied upon as affording the conclusive evidence which later the rose spots supply, but in this stage of the disease, the nervous symptoms are usually the most significant, and with the rise of temperature suffice often to indicate the character of the attack.

A precise diagnosis, however, can only be made after excluding the morbid condition with which typhoid fever in its incipiency is likely to be confounded.

Malarial remittent fever may resemble typhoid fever very closely. A history of residence in a malarious district, or of previous attacks of malarial fever, epigastric tenderness with persistent bilious vomiting and jaundice, would serve to indicate the nature of the malady. A full dose of quinine would probably yield a prompt effect in lowering the temperature and allaying symptoms, a result which could not be expected in typhoid fever. Examination of the blood would probably show the presence of malarial organisms.

Pneumonia is apt to begin more abruptly, and to be preceded by a more decided chill than typhoid fever. The temperature and pulse are usually higher than in the first day or two of that disease.

Acute indigestion, if associated with headache, fever, vomiting and diarrhœa, may readily be mistaken for beginning typhoid fever, especially in children. The character of the headache, the absence of epistaxis, the vomiting of undigested food, and the slight constitutional disturbance, would tend to exclude typhoid fever.

In children also the early differential diagnosis may be extremely difficult or impossible between typhoid fever and *acute meningitis.* Cases of typhoid fever in children or adults in which the onset is sudden, and the vomiting and headache persistent and severe, always suggest meningitis, and would probably require several days at least for accurate diagnosis. The known rarity of meningitis and the frequency of typhoid fever would of course make the latter more probable.

As a matter of clinical experience the above diseases are almost the only ones which we are likely to be called on to discriminate from typhoid fever. In the last three years cases of epidemic influenza have every now and then occurred which at first closely simulated it.

Pepper, in his latest text-book, writing of typhoid fever, says, "The whole question of the diagnosis of typhoid fever should be dominated by the view that this disease is much more likely to exist and to be overlooked, than that other affections should be mistaken for it." A rule laid down by Flint has served me oftener than any others to correct errors of early diagnosis, viz.: "If during a period too short for the career of the disease, the temperature falls to the normal standard, the disease is not typhoid fever." In applying this test, the transient effect of antipyretics, if they happen to have been administered, must of course be taken into account.

Some of you will doubtless ask yourselves the question whether it is worth while to occupy the attention of this Society with a paper, however short, which establishes nothing and which touches only upon matters of every-day experience. I have spared you the narration of any cases illustrative of the early diagnosis of typhoid fever, but one case at least I beg to recall—that of a patient whose temperature I took carefully morning and evening and whose chart showed happily a fall to normal on the twenty-first day, before I was ready with the diagnosis.

My excuse, then, for adverting to the subject of this paper, as I have hinted, is the recollection of my own early training, which taught me to use such uncommon wariness in committing myself to a positive diagnosis of typhoid fever that the patient was liable to die of perforation or some other late manifestation of the disease before announcing to his family the nature of his attack. There are, as we all know, many questions apt to arise at the outset of an illness which involve, among other important considerations, that of prognosis; the patient's possible removal to a distant point or the treatment to be adopted; and these can be decided only by a prompt diagnosis.

Medical attendance and board furnished by a hospital to an employee of a rail road company, who has been injured and disabled in its service, are not, according to a decision of the United States Circuit Court, "supplies necessary to the operation of the railroad," within the terms of a statute which gives a lien therefore.—*Med. News.*

SOME FACTS AND SUGGESTIONS CONCERNING THE CARE AND TREATMENT OF THE INSANE IN MARYLAND.*

BY GEORGE J. PRESTON, M. D.,

Professor of Physiology and Nervous Diseases, College of Physicians and Surgeons, Baltimore; Member of the American Neurological Association; etc.

In reviewing the history of the Medical and Chirurgical Faculty of Maryland, one is agreeably surprised at the prominent part taken by this ancient and honorable body in all matters affecting the public health. Questions of sanitation, quarantine, vaccination, the prevention of the spread of epidemics, the care of the insane and indigent sick, were all laid before this body for discussion, and the opinion of the Faculty was usually acted upon by the authorities of the State. This position, if we stop to consider it, was, or perhaps we might say is, logically correct. The representative medical body in the State should certainly have a voice in all matters pertaining to the public health. It is to be regretted that in some degree the State Faculty has departed from its early custom, that in its more mature years it has not maintained its youthful zeal in public affairs. There should certainly be a blending of interests. Purely scientific questions should not exclude questions relating to the public health, or the duties and privileges of the profession. The influence wielded by State medical societies in matters of State sanitation should be much greater than it is.

Acting on this conception of the duties

*Read before the Medical and Chirurgical Faculty of Maryland, Nov. 22, 1893.

of the State medical society, I have ventured to present certain facts and to make certain suggestions relating to the care and treatment of the insane within our borders. Much of what I have to say will not be new to those who have followed the work of our Lunacy Commission, and one purpose in presenting this paper is to call the attention of the profession throughout the State to the forcible and emphatic appeals and suggestions relating to additional accommodations for the insane which have been made from time to time by this body. Before discussing the present condition of the insane in our State, it may be of some interest to review briefly the work that has been done in the past and the growth of our institutions. Unfortunately the early records are very meagre and imperfect. The day of statistics had not dawned when the people of Maryland first turned their attention to the care of the insane. There is a record of an appropriation by the Legislature of $4000 for the erection of an almshouse in the year 1773. This building was of course used for the insane, but to what extent is not known. In 1797 the Legislature passed an act authorizing the erection of a hospital in or near Baltimore for the indigent sick and lunatics. This act of Legislature was apparently the result of the exertions of certain benevolent citizens of the town of Baltimore, which this same year became incorporated as a city. Asylums for the exclusive use of the insane were not numerous at this early day. It would seem that the first asylum for the use of the insane alone was built at Williamsburg, Virginia, in the year 1773, the same year in which the appropriation was made for our first almshouse. The Frankfort Asylum, near Philadelphia, was established by the Society of Friends in 1817, and McLean Asylum, at Summerville, Mass., in 1818.

The first grant made by the Legislature for the Hospital was $8000. A piece of ground was bought or donated (just which is not clear)of seven and one-half acres where the Johns Hopkins Hospital now stands. A building was erected which was called the public hospital. In the year 1808 Drs. McKenzie and Smyth obtained a lease of the hospital, and with great energy and public spirit proceeded to enlarge and improve the buildings. Money was obtained by a lottery authorized by the Legislature, and also by appropriations from both city and State. No inconsiderable sums were subscribed by the lessees and other public-spirited citizens. In 1814 this lease was renewed for ten years. Upon the death of Dr. Smyth in 1819 and of Dr. McKenzie in 1824, the lease passed into the hands of Dr. John P. McKenzie, who remained in possession of the hospital until the contract expired in 1834. In 1828 an act was passed incorporating the Maryland Hospital, and in 1834 all titles held by the city of Baltimore were vested in the State of Maryland. A condition appended to a grant made by the Legislature in 1839 was that the Hospital should be used exclusively for the care and treatment of the insane. Thus early did it become apparent that the insane and the paupers should be cared for separately. During the first fifty years of its existence, or from 1798 to 1848, the hospital received from all sources, appropriations from State and city, contributions from private individuals, and

from the lottery, $209,000. In 1852 a commission, appointed by the General Assembly, selected "Spring Grove," near Catonsville, as the site for the new hospital, and the ground was purchased and the buildings begun. The year 1861 found the buildings still uncompleted, and the outbreak of the war arrested any further progress. In 1864 another appropriation was made by the Legislature, and in 1870 the old hospital property was sold. In October, 1872, the patients were transferred from the old hospital to Spring Grove. Such, in brief, is the history of the Maryland Hospital for the Insane, and at the same time it is a short epitome of the work done for the insane in this State, or at least the most important part of such work, and also shows the chief Legislative enactments concerning the insane. In common with most institutions of a similar character, its usefulness has been curtailed through lack of sufficient means to carry out its benificent purposes. It is to be regretted that the reports of the Maryland Hospital are not sufficiently complete to furnish exact statistics of the number of insane treated during the century, almost, of its existence.

There is another institution in our State whose influence for good in the care and treatment of the insane has been far-reaching—Mount Hope Retreat. In 1840 the Sisters of Charity, who for some years had been in charge of the insane in the Maryland Hospital, severed their connection with this institution and established a hospital of their own, devoted to the treatment of the insane. The building was first located on Front Street, near Fayette, and this building proving too small for the rapidly increasing number of patients, a lot and building was purchased on the Harford Road. In 1844, Mount Hope College, situated on North Avenue, was fitted up for hospital purposes, and for a number of years answered very well, but for the third time it became necessary to enlarge the accommodations, and the present beautiful site on the Western Maryland Railroad was purchased and the present comfortable and commodious buildings were begun. Since this date, 1860, many improvements and additions have been made.

The other institutions in the State for the exclusive use of the insane do not date far enough back to require any historical notice. The Asylum at Bay View is, as is well known, under the same management as the Almshouse and Hospital Department, though having a separate medical staff. The Sheppard Asylum, with its splendid equipment, was opened in 1891 and has, if one may predict such things, a brilliant and useful future before it. Dr. Conrad's private asylum has long been favorably known, and within the past few years two institutions for the feeble-minded have been opened—one a private asylum, under the care of Dr. Fort, and the other the Maryland Home for the Feeble-minded. Among the other private asylums may be mentioned the Richard Gundry Home.

In several of the counties of the State there are asylums for the insane distinct from the county poorhouse. Among these may be mentioned Sylvan Retreat, in Alleghany Co., about one mile from Cumberland; the Cecil Co. Insane Asylum, near Elkton; Bellvue Hospital, in Washington Co., not far from Hagers-

town; Montrose Hospital, in Frederick Co.; and others. In most of the counties the insane and the paupers occupy the same institutions, and until quite recently the county jails were extensively utilized as places of confinement for the insane. These various institutions have been mentioned at some length in order to show as nearly as possible the total accommodation for the insane in the State. Of these institutions, two are under the charge of the State and city, Spring Grove and Bay View; one, Mount Hope, belonging to the Sisters of Charity; one, the Sheppard Asylum, has a private endowment and is under the care of its own board of trustees; the two institutions for the feeble-minded are: one private, the other a State institution; and two private asylums for the insane, Dr. Conrad's and the Richard Gundry Home. The county asylums are of course maintained and managed by their respective counties. Such being the accommodations for the insane (both public and private patients), let us endeavor to estimate the total number of insane in the State. The estimation of the insane population is of necessity a difficult problem. In the institutions the number of persons discharged or removed is considerable, and the deeply rooted prejudice existing in the minds of many persons against commitment to an asylum, together with the desire to conceal the fact of the existence of insanity in a family, vitiate statistics to a very great degree. Then, in the thinly settled rural districts, there are always a number of "harmless lunatics," and if these were all counted the number of insane would probably be considerably in excess of the number taken to represent the total insane population. It is safe to say that the estimates of the insane population are always below rather than above the true figures. The census of 1890 credits Maryland with 1,649 insane, or 1,579 to 1,000,000 of population. The report of the Lunacy Commission for the same year puts the number at 1,781. Taking the last report of the commission (1892) and deducting the dismissals, so as to arrive at the actual number of insane in the different institutions, both public and private near the close of the year 1892, the total is 2,045. Of this number, about 473 are in the county asylums and almshouses. In the two institutions supported by the State and city there are 797. At Mount Hope, there are 242 patients supported by the city and State. In round numbers, then, there are, or were at the close of last year, about 1,600 insane supported by the State, both city and counties. Of the four or five hundred private patients nothing need be said. Their means enable them to select their place of treatment, and we have no right to interfere. The Lunacy Commission is intrusted with the duty of seeing that they are properly taken care of and not improperly restrained or illegally detained in the asylum. It is with the remaining 1,600 that we have to do—the so-called "pauper insane." We are much too apt to look upon the unfortunate inmates of our State or county asylums as members of the great and increasing family of paupers.

A moment's consideration will show that a large proportion of the insane, supported by the State, while perhaps technically paupers, really do not belong

to this class, any more than do the cases that fill up the accident wards of our general hospitals. The nature of the disease of the insane patient renders his treatment at home impossible; the duration of his disease makes it equally impossible for his family, if he belongs to the laboring class, to pay the lowest rates of the asylum.

If the mechaic, earning his $2 or $3 a day, becomes the victim of some incurable malady (phthisis for example) he is generally cared for at his home, the wife and children contributing to his support. If this same man becomes insane it is impossible for his family to take care of him, nor can they afford to pay the lowest rate, say $5 a week, at the asylum. And, more than this, the man is dangerous to the community, and the laws of the State require that he be confined. Clearly, then, the imates of our asylums are not to be classed as ordinary paupers, although they are cared for at public expense. If, now, this proposition be true, and it hardly seems likely that it will be questioned, it must follow that the State is in some sense obligated to provide better accommodation for the insane than for the pauper class. Again, while a certain proportion of the insane, the hopelessly chronic class, require merely humane supervision, a very considerable number imperatively demand careful and special medical attention. The management and treatment of the insane, whether acute or chronic, is a very different thing to-day from what it was fifty years ago. The number has increased out of proportion to the increase of the population, and an advanced civilization demands more scientific, more humane methods of dealing with this unfortunate class. The expression usually employed when speaking of the insane "care and treatment" is a particularly felicitous one, for it implies a separation into two classes—one requiring care, the other treatment.

In regard to the first class the chronic insane, their time of probation has expired; nothing, or at least very little, can be hoped for from treatment so far as their disease is concerned, and they have simply to be provided for.

Humanity demands that their deplorable existence be rendered as comfortable as possible. The State requires their maintenance to be as economical as possible. Careful series of experiments have made these two things compatible. Among the chronic insane there are many classes, ranging from the terminal dement, in whom the last ray of intelligence has faded, whose habits are filthy, who is many degrees lower than the brute—up to the paranoiac, whose mind is clear on all subjects save one. It would be manifestly improper to put these two classes together, hence there must be an intelligent classification of the chronic insane, and there must be space enough afforded to carry out, as far as necessary, this classification. The wants of the inmates must be attended to by a sufficient number of attendants, and the general management must be in the hands of a competent medical man. On the economic side, there should be a farm large enough to supply the needs of the institution, and at the same time to utilize the work of those patients who are able to perform such labor. The second class, the acute cases, require something different. Here

all energies are bent upon curing the patient. Classification of the patients is of even greater importance than in the case of the chronic insane. For the proper treatment of the acute insane, there must be a thoroughly equipped modern hospital, arrangements for electrical and hydrotherapeutic treatment, a full complement of well-trained nurses and attendants, a gymnasium, provision for a great variety of amusements, such as billiard tables, tennis courts and the like. These are some of the requirements of a modern asylum for the treatment of acute cases, and such an institution should be under the care of a specialist, with a sufficient number of assistants to aid him in his work.

Now, if this brief outline of the management of the insane be admitted to be correct in its main features, it must follow that the care and treatment of the insane should be undertaken by the State. The State should assume this obligation, first, because it would be greatly to the advantage of the unfortunate sufferers. This proposition is self-evident. No county, however prosperous (this refers to the State of Maryland), can afford a properly equipped institution and a sufficient medical staff. The county asylum may be reasonably comfortable and the medical superintendent competent to manage it, but no county, in this State at least, is warranted in the expenditure of sufficient money to maintain a properly equipped modern asylum. In the second place, it will be found more economical in the long run for the State to care for the insane in the manner specified above. A properly equipped asylum, with a well-trained medical superintendent who is not too greatly hampered by details of subsistence, will show a far higher percentage of cures than are ever obtained in the county almshouses or asylums, and while the cost of maintenance of the individual patient is greater, the duration of his stay in the asylum, and the much greater chance of cure, far over-balance the increased expenditure. For confirmation of some of the statements made above, let us turn to our own statistics. In the State of Maryland there were, at the date of the last report of the Lunacy Commission, nearly 500, insane in the county almshouses and asylums, and while, no doubt they are in most instances reasonably comfortable, still there can be no question but that under State care both the unfortunate patients and the counties would be gainers. In some cases the accommodations for the insane, in the counties, judging from the report of of the Lunacy Commission, are entirely inadequate, and in a few instances disgraceful. Take, for example, the following quotations from the above mentioned report for 1892: "Poorly attended and in some instances much in need of bedroom comforts." "The two wards for the colored poor uncleanly and without necessary bed comforts." "The interior of the buildings were found very untidy and some of the rooms, as well as their occupants, were very dirty." "No improvements have been made at this old dilapidated almshouse." "*Little attention is paid to the separation of the colored sexes, and the form of restraint* (*chains*) *is inhuman!*"

Shade of Pinel! and this at the close of the 19th century! Summing up our facts, we find that there are something

like 1,600 insane who are a charge upon the public. Of this number, about 500 are cared for in the county institutions, or about one-third of the whole number; and the remaining two-thirds, amounting to about 1,100 at the last report, in the three institutions near the city—Spring Grove, Bay View, Mount Hope.

The provision for the insane in the county almshouses, judging from the report of the Lunacy Commission, is, to say the very least, inadequate. The two public asylums, Spring Grove and Bay View, have for some years past been greatly overcrowed, and their usefulness thereby much curtailed.

In view of these facts, the following suggestions are offered.

In the first place, the State should assume the entire care and control of all the public insane patients within her borders. The arguments put forth in the maintenance of this position have been already given at some length. In this State it would be a much easier matter for the State to assume the entire control of its insane than in some of the larger States, where the numbers of insane are far greater and where the area is so much larger. It would be a comparatively easy thing for all the counties, with a very few exceptions, to send their insane to Baltimore. Granted that the State assume this responsibility, there should be a distinct separation into acute and chronic cases, and separate institutions for the reception of each class. Spring Grove Asylum should be set apart for acute cases only. It is admirably adapted for this work, having an exceptionally fine location near the city, and being already equipped for hospital work. It can, or easily might be made, to accommodate all our acute cases for many years to come.

For the chronic insane the State should purchase a farm in some healthy locality, reasonably accessible, and should construct separate buildings as might be needed, or as it could afford. If it seemed advisable, an epileptic colony could be an adjunct to this chronic asylum. The farm should be large enough to supply in great part the needs of the institution. Only cases adjudged chronic should be admitted, and in a few years, after the system had become well established, all cases, practically, would have first passed through the asylum for the acute insane. These two institutions should contain all the insane for whose support the State is responsible.

The insane at Bay View Asylum should be removed, and the much needed room utilized for the proper work of the institution. Such, in brief and without detail, are the suggestions offered, and for them the claim is advanced that their adoption would greatly redound to the comfort of the unfortunate class of mentally diseased, and that in the long run the expense to the State would be less than under the present system.

The question of the necessary expense in the care of the insane is a very difficult one to discuss. On the one hand, a high rate may imply extravagance and misappropriation, and, on the other, a very low rate is suggestive of insufficient provision and unskillful treatment. The golden mean which we should ever strive after is to expend as much money upon the care of our insane as is consistent with the financial condition of the State and see that this fund is judiciously applied.

In order to have no misunderstanding as to the transfer of patients from the acute to the chronic asylum it would perhaps be advisable to have both institutions under the management of the same board of visitors, or at least to have certain members common to the two boards. Of course the decision of the transfer of a case from the acute to the chronic asylum should rest with the superintendent of the former institution.

Another suggestion, while applying more to the city than to the State, might be mentioned here. There has long been a crying need for a detention hospital, or ward, where persons becoming suddenly insane, or those suspected of insanity, can be provided for until their cases are inquired into and commitment to asylum made out in due form. The general hospitals cannot take such cases, and these unfortunate persons are compelled to remain in the station-houses until their cases are disposed of. Such a ward would be very useful for confining the cranks who amuse themselves by shooting presidents and mayors, or blowing up millionaires with dynamite. Many of these persons are well known to the police, but there is really no place to send them. It would be perfectly proper to commit such cases to the detention ward, where their condition could be studied and a proper disposition made of them. If such a ward, which need be of very moderate dimensions, were established in connection with one of our hospitals, the cost of maintaining it would be very small and its sphere of usefulness very great.

It may be objected that the somewhat crude suggestions here offered are too radical in their scope, perhaps too ideal, and that we ought to demand of our legislators something more moderate, something they would be likelier to grant. This objection, in my humble opinion, is not a valid one. The profession of the State, represented by this honorable body, is, or should be, the conservitor of the public health; to it belongs the privilege, and upon it devolves the responsibility, of advising the best method of caring for those citizens who, through disease, have become the wards of the State.

It is for us to say in what manner the interests of this unfortunate and unhappy class will be best subserved; it is for those who manage the affairs of our State and administer its finances, to say how far our suggestions are feasible. We should tell them what we think ought to be done, and let the responsibility of modifying the suggestions rest with them. As we all know, something must be done, and that speedily, to relieve our overcrowded asylums. Not only is the work of the asylums greatly hampered by the crowded state of their wards, but patients seeking admission have of necessity been turned away. In making any suggestions for additional accommodation for the insane in our State, we are acting for the future, and not merely for the present, and hence our views should be wide enough to take in several decades yet to come. With the rapid increase of the population, and the more than proportionate increase of the insane, with a higher civilization and a wider philanthropy, we should endeavor to do more for those who are to come than those who are gone have done for us. Let us so plan, so advise, that in the coming years those who take our places will say of us, "They builded better than they knew."

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD NOV. 17, 1893.

The 285th regular meeting was called to order by the President, Dr. J. Edwin Michael.

Dr. I. R. Trimble read a paper on WOUNDS OF THE BLADDER AND URETHRA.

Dr. W. F. Lockwood then read a paper ON THE EARLY DIAGNOSIS OF TYPHOID FEVER.

Dr. Julius Friedenwald followed with a paper on THE DIAZO-REACTION OF EHRLICH. The reaction is carried out in the following manner:

Two solutions are prepared:

(A) 2 grams sulphonilic acid, 55 cc. hydrochloric acid, 1000cc. distilled water.

(B) 0.5 per cent. solution of nitrate of soda.

In order to perform the reaction, 50 parts of A and 1 part of B are mixed and equal parts of this reagent and of urine placed in a test-tube and saturated with ammonia. In those cases in which the reaction is positive, the solution assumes a carmine red color, which on shaking must also be visible in the foam. If the test-tube is allowed to stand 24 hours a greenish precipitate is found.

Dr. Friedenwald reviewed the literature of the reaction and showed that the objections offered to it depend upon errors in the performance of the test.

1. Very weak solutions of sodium nitrate, $\frac{1}{2}$ per cent., should be used.

2. The alcohol test (as proposed by Von Joksch and others) is not to be employed.

3. A positive reaction is only one in which the red reaction is present in the foam.

Dr. Friedenwald's observations with this reagent include over 3,000 reactions.

Twenty-one cases of typhoid fever were examined; the reaction was absent in but one case. The reaction was obtained as early as the fourth day of the disease and as late as the twenty-sixth. From his observations in typhoid fever he concludes: 1. That the reaction is very constant in this disease. 2. That it makes its appearance usually within the first week. 3. That the reaction gradually disappears between the end of the second and third weeks.

Examinations were made in forty-three cases of pulmonary tuberculosis. Of these, 29 were severe cases with almost constant reaction, 14 were light forms which did not show the reaction. Of the 29 severe cases, 12 died while still under observation; 8 are still under observation in an unimproved condition. The presence of the reaction in this disease extending over long periods of time may therefore be regarded as a grave sign.

The reaction was also found to be present in: 3 cases of erysipelas (for several days); 1 of bone abscess (tuberculous); 1 liver abscess; 1 suppurative glandular disease of the neck; 1 tubercular hip-joint disease; 1 spinal disease; 1 pneumonia (very grave, died); 1 cancer of the stomach; 1 septicæmia.

The reaction was never obtained in healthy individuals nor in many disorders of various kinds, including 21 cases of malaria, 11 cases of diabetes, 42 cases of gastro-intestinal catarrh.

Dr. Friedenwald's observations therefore entirely confirm those of Ehrlich. He concluded with emphasizing Ehrlich's statements:

1. The diazo-reaction is of great diagnostic value in typhoid fever.

2. If the cases show a slight or no reaction between the fifth and eighth days, other appearances pointing to typhoid fever, it can be looked upon at once as an exceedingly light form and the prognosis made accordingly.

3. Gastro-intestinal catarrhs, accompanied by fever, always run their course without a reaction.

4. Very marked and constant reaction may accompany mild forms of typhoid fever and do not justify a bad prognosis.

5. Reactions appearing continuously for a long time in phthisis pulmonalis (two months) always indicate a grave prognosis.

Dr. Jos. T. Smith remarked that except during an epidemic we are hardly expecting to see typhoid in our offices. Oftentimes much aid will be obtained by learning the recent abode of the patient, whether he has been living in a "malarious district" or a region infected with typhoid. An important point is to get suspicious cases to bed and watch the temperature.

Dr. Geo. J. Preston: Some malarial cases of irregular character simulate typhoid very closely. As an illustration of the difficult of recognizing typhoid by clinical appearances, I call to mind two cases seen at the City Hospital.

Case I. Had high evening temperature, morning remissions, coated tongue, abdominal tenderness and all symptoms save "rose spots." Died in coma. Autopsy showed no evidence of typhoid, and, in fact, no other cause for death.

Case II. Second day after entrance patient had peculiar irregular temperature accompanied by wild delirium. No classical symptoms of typhoid, yet upon autopsy the bowel was found to be filled with typhoid ulcers. I have had most trouble to distinguish it from acute miliary tuberculosis, and recall one case of meningitis which closely resembled tyhpoid.

I have followed Dr. Friedenwald this summer in his tests and think while they are not conclusive, they are of particular value in distinguishing from malaria. It has not failed once in our cases. Possible some good might come of the use of sulphonilic acid in treatment of typhoid.

Dr. J. E. Atkinson: Several years ago while in charge of the Medical Wards at Bay View I made use of Ehrlich's test and found the reaction not only in typhoid but in pneumonia, phthisis and I think sometimes in malarial fever. The main objection to its use was that the reaction was common in acute miliary tuberculosis and other diseases which simulate typhoid.

My experience is that even with most careful examination, I often cannot make a diagnosis in a few days. I believe many cases of typhoid are never recognized and that ambulatory cases are very common. Some cases go on day after day with malaise, slight elevation of temperature—never over 1°—no epistaxis, no rose spots,&c.,and then suddenly develop unmistakable typhoid symptoms. So I have come to regard every case of continued fever which cannot be classified as some other disease as typhoid.

Especially do I think this applicable to children, though I have not proved it by autopsies, as children rarely die of the disease.

Dr. W. T. Howard Jr.: Dr. Welch once said that "In this latitude, any case of continued fever which is not malarial, septicæmic or tubercular is typhoid."

You can eliminate the first three diseases by microscopic examination of the blood.

In the blood of typhoid there is no leucocytosis, or increase of poly-nuclear cells.

I have failed to grow the typhoid germ from blood of living subjects, but have once obtained them from the urine.

Dr. John Hewetson reported the use of Ehrlich's test at the Johns Hopkins Hospital. We have just finished a summary of the 229 cases treated during the past four years. Of these the test was carefully made in only the last 196, and the reaction obtained in 136 instances. As many patients, however, came to us in the third or fourth week of the disease, it is not fair to say that the reaction was absent in 30 per cent. of our cases, for it may have been present in the earlier stages.

Indeed, it is quite common to find it disappear from the urine after the second week. We are not able to give statistics as regards the time of appearance, duration, etc., from the entire number, but from a study of 50 cases it occurred in 77 per cent. in the first week, 37 per cent. in the second, 47 per cent. in the third and 17 per cent. in the fourth, occurring less frequently after this period, being however quite often present during a relapse. As far as I can remember the reaction was in no case obtained before the fourth day. It was frequently found in tuberculosis—34 per cent. of all cases showing the reaction—and in pneumonia, measles and some cases of malarial fever. The reaction seems to fail us just when we need it most, *i. e.*, in differentiating typhoid fever from acute miliary tuberculosis.

It is a sign, however, which we cannot ignore, as is shown in one case which I shall briefly relate.

A patient was admitted to the hospital in March, 1892, with symptoms of a severe entero-colitis; the stools very frequently contained blood and mucus. The diarrhœa was with difficulty checked.

He apparently recovered completely and was discharged in April. Five weeks later he returned with a severe diarrhœa—five to twenty-four stools in the twenty-four hours — and symptoms which in every way corresponded to his previous attack. The temperature did not range high, only once or twice touching 102°. His general condition in every way resembled that of his first admission except that his urine showed a distinct diazo reaction, wich persisted until death, which occurred 5 days after entrance. Autopsy showed typical typhoid lesions, the glands in the small and large intestine being swollen and infiltrated.

This, then, would go to support Von Noordin's view, that the cases of gastro-intestinal catarrh with a persistent diazo-reaction in the urine should be regarded as cases of typhoid fever, but we have not seen it present frequently enough to warrant our giving a decided opinion on the subject.

The degree of value to be attached to

the presence of this reaction in the urine for diagnostic purpose is a question. That it is an aid seems undoubted and we cannot afford to neglect anything which may assist us in this often extremely difficult question.

H. O. Reik, M. D., Secretary,
525 N. Howard St.

A CASE OF ASCITES; RECOVERY.

J. M. Walker, M. B., C. M. Edin., writes to the *Lancet:* Extensive accumulations of fluid within the peritoneal cavity so frequently resist the best directed efforts to promote their absorption and necessitate a recourse to paracentesis that a short account of the following case, in which complete recovery—as far as the dropsy was concerned—resulted from purely medical treatment, may prove to be interesting to readers of this paper.

A man aged forty-eight consulted me on Aug. 1st last in consequence of his abdomen having recently become enormously distended, and a very slight examination sufficed to prove that he was suffering from ascites, a history of many years' excessive indulgence in alcohol leaving little room for doubt that cirrhosis of the liver was the cause.

There was no œdema of the legs or other part of the body. The urine, of which only three or four ounces were passed in the twenty-four hours, was loaded with lithates and contained some bile, but was free from albumen. The heart and lungs were healthy, and the abdominal girth measured forty-five inches. I prescribed a mixture containing acetate of potassium, spirit of nitrous ether, tincture of squills, tincture of digitalis, and decoction of scoparius, a considerable increase in the flow of urine (from which the lithates and bile disappeared by degrees) taking place in the course of a day or two. In addition to this the abdomen gradually became softer, and its girth was reduced to forty-three inches. The improvement, though, did not continue, notwithstanding that other diuretics and an electuary of compound jalap powder and confection of senna were subsequently tried.

The patient strongly objected to paracentesis being performed, and I saw him on Aug. 29th in consultation with Sir James Sawyer, who prescribed the following: iodide of potassium, one scruple; muriated ammonia, four scruples; carbonate of ammonia, one scruple; bicarbonate of soda, one drachm; liquid extract of taraxacum, half an once; dill water to eight ounces. One ounce with half an ounce of lime-juice to be taken three times a day. The electuary to be continued. Within a week of commencing the above the amount of fluid had sensibly diminished, and by Sept. 27th it had completely disappeared, the abdominal girth measuring thirty-five inches. The patient, who had become greatly emaciated during the course of his illness, rapidly gained flesh and strength, and in a little more than two months from the date of my first seeing him was actively engaged in the pursuit of his business, and was able to walk several miles daily. The case is an instructive one as showing what may be accomplished by persevering with suitable remedies and the advantage to be gained by varying the latter should one class fail to bring about the desired result. Attention also may be drawn to the value of chloride of ammonium in such cases.

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BALTIMORE, DECEMBER 16, 1893.

Editorial.

LEGISLATION IN MARYLAND FOR THE PREVENTION OF BLINDNESS.

In the last number of the JOURNAL we spoke of the importance of having the medical practice law amended by the Legislature which meets next month. It is our desire now to call the special attention of physicians in Maryland to another bill which will be presented to our lawmakers: "to prevent blindness." A visit to a blind-school or asylum, or even an almshouse, cannot fail to impress one, at all familiar with eye troubles, with the number of persons blind from preventable causes. Sympathetic ophthalmia and ophthalmia neonatorum stand out prominently as such avoidable causes of loss of sight. Loss of sight means usually a wasted life; a burden on the family, if it can afford the blind one's support, on the State, if it cannot. The money loss each year to the country from the support of those unnecessarily blind, as well as from the fact that the blind are usually "non-producers," has been found to be tremendous. Oculists have for a number of years been asking how the number of cases of *avoidable* blindness can be lessened. In this connection, ophthalmia neonatorum is at once the most prolific cause of avoidable blindness, and the one most remediable. Interest in the subject has been steadily growing in the United States since Dr. Lucien Howe, of Buffalo, N. Y., presented a paper to the American Ophthalmological Society in 1887, setting forth the increase in blindness in the United States at a rate out of proportion to the increase in population.

In many of the States since then oculists have agitated the subject, trying to find the amount of blindness which could, in one way or another, be prevented. In Maryland, work in this direction started in 1891. At the annual meeting of the Medical and Chirurgical Faculty, Dr. Hiram Woods, of Baltimore, read a paper on "Blindness in the United States."

He stated that he had found by personal examination that of the pupils at the Maryland School for the Blind, 17.6 per cent. had lost their sight from infantile ophthalmia.

A committee, consisting of Drs. Rohé, Michael, H. Friendenwald and Woods, was appointed by the Faculty to take such steps as were deemed proper to prevent this blindness. So far the work of this committee has been educational. Letters of warning and instruction have been sent to midwives, and notices set-

ting forth the symptoms and dangers of ophthalmia neonatorum have been posted in the city dispensaries. All this has done good; but the committee in Maryland has been forced to the same conclusion reached by investigators elsewhere:—the majority of babies who lose sight from this disease do so because they are not put at once under proper treatment. While, unfortunately, physicians are sometimes to blame, the fault, in most instances, lies at the door of the midwife, who has been the sole attendant at the child's birth. She has either not noticed the redness and the mattering of the eyes, or if she has, has failed to realize their meaning. We have no law whatever regulating the practice of midwifery in Maryland. A Baltimore City ordinance requires registration, and this is all. The problem, then, is this:

How can the baby be reached in time to prevent or cure the disease? In some of the European countries the law compels women to understand Credé's prophylactic method before they can obtain a midwife license. But in the absence of a law compelling midwives to understand midwifery, or of a school where they could obtain such instruction, were a law passed, the best course seems to be to compel them to report these cases to physicians. The latter either know the proper way to treat them, or, if they do not, are legally responsible for their ignorance. Such laws already exist in New York, Maine and Rhode Island. The essential feature of all of them is the compulsory reporting by the midwife or nurse, in charge of an infant, to a physician, of any redness or mattering of a baby's eyes as soon as these phenomena appear. Penalties of fine or imprisonment are attached

The three laws mentioned may be found in an article by Dr. Howe in the *Journal of the American Medical Association*, for Nov. 25th, 1893. In this article Dr. Howe lays stress upon three things apt to result from legislation upon this subject. 1. "The nurse is made to appreciate her responsibility, not only in that case, but in others. 2. The parents also become alarmed when they know that the disease is sufficiently serious to be the subject of special legistion, so that in choosing a practitioner they select with rather more than ordinary care. 3. As for the physician himself, if he accepts the case, he feels he must understand it thoroughly."

The preventability and curability of the disease are well established. Carelessness and ignorance are the foes to be met, and we agree with those who have looked into the matter, that legislation promises the best results.

The committee of the Faculty has adopted a bill for presentation to the next Legislature. It requires midwives to report at once any redness or mattering of an infant's eye to a physician, under penalty of not more than one hundred dollars fine, or imprisonment not exceeding six months. The bill is to all intents and purposes the same as the Maine law.

We earnestly ask for the committee the help of the profession in the State. The enactment of such a law would be a work of philanthropy. An arrest and conviction under it would do more to prevent the loss of sight from this disease than any amount of lecturing or writing. We trust our readers will take

enough personal interest in this matter to see such members of the Legislature as they can reach, explain to them its importance, and try to enlist their interest.

THE PROGRESS OF MEDICAL WORK IN THE SOUTH.

Six years ago a few prominent surgeons in the South organized the Southern Surgical and Gynæcological Association with a view of stimulating an interest in surgical work among Southern surgeons. The recent annual meeting of this Association in New Orleans shows a remarkable growth in the influence and work of this organization, and the widespread interest it has aroused among the leading surgeons, not only in the South, but in the North and West.

There are few of the national medical organizations doing more and better work than this Association, and not one that draws larger attendances to its annual sessions. Such results are exceedingly gratifying to Southern men. The stimulus of such work to the young and progressive surgeon of the South is very manifest. In the field of general surgery and of gynæcological surgery, these men are fast forging to the front and their contributions to the science and literature of these respective branches of surgery compare most favorably with the work of older and more distinguished bodies. The fact that representative men from New York, Baltimore, Cincinnati, Louisville and St. Louis find time to attend the annual meetings of the Southern Surgical and Gynæcological Association and contribute to the work of these meetings is an indication that the South is presenting a most desirable field for the exercise of medical activity. The influence of this organization upon the profession of the South is noteworthy from the fact that it has brought out only the Southern surgeon into prominence, but it has destroyed all sectional feeling by bringing the surgeon from the North into cordial professional and social relations with his Southern brother.

Science is cosmopolitan and should recognize no boundaries in the exercise of its functions.

Its domain is broadened by such associations as are strengthened by the Southern Surgical and Gynæcological Association. This organization is to be commended for its liberal spirit and generous rivalry in surgical progress. In other organizations this work of progress in the South is still further illustrated. The recent meeting of the Tri-State Medical Society of Alabama, Georgia and Tennessee, held in Chattanooga, was a most creditable affair. The work of this society was confined to its own membership. But this fact does no discredit to the excellent character of work accomplished at the recent session. No one can read the proceedings of this society without realizing the remarkable growth of interest in scientific medicine in a section of our country which a few years ago was little known in a professional way to the profession of the country at large. The names of new men appear as authors of papers or in general discussion in a light to reflect great credit upon their work and to indicate larger development in the active professional work of their respective States.

In Virginia and North Carolina we need only mention the excellent work

which is being done by their respective State medical societies. Here in Maryland much has been done and much remains to be done; still we can take encouragement in the general progress which has manifested itself in the past five years. All along the line the South is up and doing. Let this work stimulate Southern medical men with larger hope and enthusiasm.

Reviews, Books and Pamphlets

A Text-Book of Ophthalmology. By William F. Norris, M. D., Professor of Ophthalmology in the University of Pennsylvania; and Charles A. Oliver, M. D., Surgeon to Wills Eye Hospital, Philadelphia. In one very handsome octave volume of 641 pages, with 357 engravings and 5 colored plates. Cloth, $5.00; leather, $6.00. Philadelphia: Lea Brothers & Co., 1893.

As was to be expected, this book is entitled to rank among the best of our text-books on ophthalmology. Dr. Oliver writes the first ten chapters, comprising 280 pages, in his usual clear style. The first three chapters are devoted respectively to the embryology, anatomy and physiology of the eye and include all one could wish. Chapter IV, on "optics," is especially well written. Many of the diagrams are original, and all of them instructive. On page 132, there is, strange to say, an incomplete definition of the "secondary axes of lenses:" "rays which do not pass through the centre of curvature are secondary axes." There can be an infinite number of rays "which do not pass through the centre of curvature"—indeed, go nowhere near this centre—but such rays are not necessarily "secondary axes." A typographical error on the same page makes the posterior nodal point of a convex lens identical with the anterior point in the accompanying diagram. Objection is made on pp. 135-137 to the old method of designating prisms by their angle, preference being given to the "centrad" and "prism diopter."

On page 148, fig. 123, the *angle alpha* is made at the junction of the "optic axis," and the "visual line." Usually, this angle is defined as the intersection of the visual line, and the "major axis of the corneal ellipse." This may and may not be the "optic axis"—generally is not. There is, apparently, an absurd mistake on page 169. In the supposed case of a vertical prism before the left eye and the crossing of the vertical images of a candle at 20 feet showing a preponderance of external rectus action, the reader is told that the amount of the error can be measured by substituting prisms with their *bases in* before the *right* eye, or with their *bases out* before the *left* eye, until the two images are made to appear upon the same vertical line. This can, from the construction of the sentence, hardly be a typographical error. We do not know just what the author means by diagnosing the amount of *crossed diplopia* by putting before *either* eye a prism, *base out.*

Dr. Oliver thinks the ophthalmometer has not yet been brought to the degree of excellence where it can take the place of mydriatics; that it is very easy to make mistakes with it, but that it is

a scientific instrument, and has come to stay. Altogether, Dr. Oliver has handled his subject in a masterly way. The chapter on "the correction of errors of refraction and accommodation" is full of suggestions which can help one out of perplexities he constantly meets.

There is but one adverse criticism to be made upon the clinical portion of the book, by the senior editor, Dr. Norris. As a whole, it is just what a practitioner needs—a clear, brief statement of tried and reliable methods of treatment.

It is the handling of recent suggestions in ocular therapeutics which, it seems to us, is open to criticism. Men who will read this book at all will want to know not only the opinion of its eminent author upon these suggestions, but the experience upon which this opinion is formed. Optico-ciliary neurotomy, for instance, is defined, condemned and dismissed in eight lines on page 304. On page 323 we find in about one-half page a dozen remedies for trachoma. Then we read: "In the opinion of the author, all processes which aim at destroying the granulations . . are unjustifiable, and go far to augment any subsequent and inevitable cicatricial contraction." A foot-note admits that there are not many surgeons who hold this opinion; but the experience upon which it is founded is not given.

The merits or demerits of simple cataract extraction are inadequately discussed, while artificial ripening is not mentioned.

The index needs re-writing. The following are some of the common words not in it: "Buphthalmus, boric acid, cocaine, decentering, diplopia, epiphora, gonorrhœal ophthalmia, metre angle.

A Hand-Book of Ophthalmic Science and Practice. By HENRY E. JULER, F. R. C. S., Ophthalmic Surgeon to St. Mary's Hospital, Surgeon to the Royal Westminster Ophthalmic Hospital, London. New (second) edition revised and enlarged. In one handsome octavo volume of 562 pages, with 201 engravings, 17 colored plates, test-types and color-blindness test. Cloth, $5.50; leather, $6.50. Philadelphia: Lea Brothers & Co., 1893.

The second edition of Dr. Juler's book is about 100 pages larger than the first, published in 1884. Most of the additional space is given to the recent advances in ophthalmology. More than two thirds of the book is devoted to diseases of the eye; optics and refraction not receiving from this celebrated English author as much attention and discussion as most of our American book-writers give them. There are no special chapters on anatomy and physiology. These are described in the chapters devoted to the diseases of each structure. The book is, as a whole, worthy of high commendation.

The operative treatment of trachoma is advised, but the method of "expression" by forceps is not given. Most American surgeons, we think, will discard the proposition to anoint the lids with iodoform ointment after cataract extraction. The early inspection—after 24 hours—of the eye, after *simple* extraction, is advised, and the immediate excision of an iritic-hernia, if such a thing has occurred.

The publisher's work is faultless. The wood-cuts, photographs and colored plates are beautiful pieces of work.

Medical Progress.

THE DANGER OF EATING OLD MUSHROOMS.

All the members of a family of seven persons were recently taken seriously ill after eating a dish of mushrooms. The symptoms were those of irritant poisoning, and the mother of the family succumbed. It is quite possible that the fungi eaten in this case were real mushrooms, for they are liable to become acrid with age. A fungus, as most persons know, springs up very quickly, attaining its full development in a very short period; and the majority of them decay as rapidly as they grow, or rather expand, because the appearance of the fungus above ground is the expansion of a previously formed cellular structure. No sooner has this body reached its full size than it usually begins to decompose; and it is supposed that the noxious property is due to absorption from the medium in which the fungus grows rather than to secretion within its own tissues. It is not difficult to determine when a mushroom, or any other agaric, is unfit for food. So soon as the brightness of the color of the gills—the lamellate under part of the cap—disappears, the quality of the fungus deteriorates, and it should be avoided. It is true that many persons eat mushrooms with blackened gills without experiencing any ill-effects; but we repeat the warning we have often given. Do not eat any fungus that has passed the firm, bright stage of its existence. Puffballs and truffles should be firm, solid, and white, or whitish, when cut. through.—*Brit. Med. Jour.*

THE CURABILITY OF TUBERCULOUS PERITONITIS.

Most modern writers agree in regarding the absorption of tubercle deposited on the surface of the peritoneum as a frequent occurrence. Long before laparotomy was heard of as a remedy for this condition, inunction of the abdominal parietes with liniment of mercury or with oleate of mercury had determined many a cure at Guy's Hospital. From a discussion that arose on this subject at the Societe Medicale des Hôpitaux on the 27th ult. it would appear that a variety of therapeutical means suffice to bring about the same happy result. Thus, M. Rendu presented a woman who had been cured by intraperitoneal injections of camphorated naphthol. Admitted into the ward in May with considerable ascites and other unmistakable signs of tuberculous peritonitis, seven Pravaz syringefuls of pure camphorated naphthol were introduced into the abdominal cavity after this had been emptied of seven litres of fluid. Some fever and pain resulted, but both disappeared in a few days. No return of the effusion was noted, and the altered condition of the abdomen enabled a diffused mass of tuberculous deposit to be distinguished. This mass (*gâteau*) became gradually absorbed, and by Aug. 15th the abdominal walls had regained all their normal suppleness. At present it would be impossible for any physician to suspect the former existence of tuberculous peritonitis. In the course of discussion that followed the reading of M. Rendu's paper M. du Cazal remarked that of all manifestations of tuberculosis, that affecting the peritoneum was the one that had the greatest ten-

dency towards recovery, and this under the most diversified forms of treatment —e. g., blisters, local applications of tinctures of iodine or of collodion, &c. Stranger still, M. Le Gendre said that he had seen tuberculous peritonitis in a young girl disappear completely in consequence of regular excercise on a tricycle. With regard to the employment of camphorated naphthol, both MM. Le Gendre and Fernet uttered a note of warning, the former stating that he had more than once seen animals into whose peritoneal cavity this substance had been introduced succumb in convulsions.—*Lancet.*

Medical Items.

Dr. Claude Van Bibber, whose office was formerly at 26 W. Franklin St , has removed to 805 N. Charles Street, 3rd door north of Madison Street.

The number of persons on whom the decree of Doctor of Medicine was conferred in the seven medical faculties of France during the academic year 1891-92 was 635, being an increase of 41 as compared with the previous year.

The late Mr. Charles Edward Horsfall, of Liverpool, who died in August last, has bequeathed the following among other Liverpool charities: Blue Coat Hospital, £1,200; Royal Infirmary, £800; Children's Infirmary, £800; Dispensaries, £800; Eye and Ear Infirmary, £500; Hahnemann Hospital, £500; and Home for Incurables, £500.

It is said that Bismarck once sent a challenge to Virchow because of some frank speaking on the part of the great pathologist. The latter instantly remarked that as the challenged party he had the choice of weapons, and held up two sausages apparently exactly alike, saying: "One of these is filled with deadly trichinæ, and the other is perfectly healthy. Let Bismarck choose which of these he will eat, and eat it, and I will eat the other." The duel was not fought.—*Ex.*

Mr. W. B. Saunders, publisher, of Philadelphia, announces the American Text-Book of Gynæcology as ready for early issue. It is the joint work of Drs. Howard Kelley, Pryor, Byford, Baldy, Tuttle, and others, who stand before the profession for all that is progressive in gynæcology. The work will contain operations not before described in any other book—notably ablation of fibroid uterus. It is designed as a profusely illustrated reference book for the practitioner, and every practical detail of treatment is precisely stated.

Southern Pines, Moore County, North Carolina, is a new winter health resort just coming into prominent notice. It is located in the high, dry, long, leaf pine sand hills, amid the tar, pitch and turpentine district. Thousands of Northern invalids have visited the place and many remarkable cures have been effected. Prominent physicians have visited the place for investigation and without a single exception say it is the best in the United States, and we are specially requested by Mr. John T. Patrick, Commissioner of Immigration for the Southern States, to invite physicians of the Northern and Western States to visit the place and investigate in the interest of their patients. Any physician desiring information can address Mr. Patrick at Pine Bluff, N. C.

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Original Articles.

SOME NERVOUS EFFECTS OF GASTRIC DISORDERS.*

BY A. K. BOND, M. D.,
OF BALTIMORE.

Since the beginning of medicine we have known that soluble poisons taken into the mouth will pass through the walls of the digestive canal into the blood and so produce serious if not fatal disturbance of thegeneral nervous system. And it has been long suspected that, from the contents of the digestive canal itself, poisons are sometimes elaborated which, when absorbed into the blood, produce equally deadly though perhaps less rapid disorder of function in the great nerve centres. In recent years clinical observation, aided by laboratory research, has not only isolated some of these poisonous digestion-products, but traced with considerable accuracy the symptoms they cause. The result encourages us to believe that the source of very many disordered conditions of the blood and nervous systems, hitherto inexplicable, is in the digestive canal.

The condition known as diabetes mellitus is believed to be in most cases associated with digestive derangement. I think its nervous phenomena are in some instances directly dependent on imperfect digestion.

I have a diabetic patient, who can eat with impunity, at a friend's house amid cheerful company, starchy and even saccharine substances, which at home, where digestion was not stimulated by diverting conversation, would produce various nervous phenomena.

Woman is built upon a net-work of nerves, which have to do with her sexual nature, and which lie closest to the surface of her consciousness at a number of

*Read before the Clinical Society of Maryland, November 17th, 1893.

points—in the uterus, ovaries or mammary glands, behind the scapula, in the small of the back and along certain regions above or below the mammæ. Any condition which lowers her general health sets these nerves of sex vibrating, even though no local disease can be found in such regions. In any woman whose nerve-force is greatly lowered the physician may almost certainly detect, upon questioning, a "spine-ache," "ovary ache," or a "womb-ache," though there be no local disease in any of these regions, and her sexual life has been normal. In such patients local pains in these sex-nerves are readily called forth by disturbance in other organs, not of the sex system.

Among such causes, digestive disorder ranks high and the agent which clears the bowels and restores the intestinal secretion strikes at the roof of the "ache," while one which binds up the bowels prolongs and establishes the "ache," even though, like opium, it temporarily deadens pain. A striking illustration occurs in the following cases.

I was asked to see a patient, under treatment for cancer or ulcer of cervix uteri. She had within the past week suffered violent paroxysms of pain in lower abdomen, supposed to be due to inflammation of internal sex-organs. For first paroxysm a hypodermic of morphia had been given, which soothed the pain and restored comfort. Next day a recurrence yielded to same treatment. During next few days paroxyms increased to several a day. I first saw patient in a paroxysm and the position of the feet during the spasm reminded me of "hysterical" convulsions and aroused suspicion of nervous irritation instead of pelvic inflammation. After free catharsis by Epsom salt there was no return of pain or spasm. The more thoroughly I learn the use of aperient medicines, the less frequently do I have to use opiates. I am convinced that sudden yet persistent disturbance of the nervous system in its psychic, motor and sensory departments may arise from abnormal conditions in the intestinal tract.

With reference to the influence of abnormal digestion upon the motor nerve centres I can cite several cases in which violent convulsions seemed to so originate.

Case I. In December, 1891, I attended a middle-aged woman for epileptic convulsions, lasting 9 hours in spite of chloroform, nitrate of amyl and enemata of pot. bromid. Drop doses of croton oil in castor oil brought away a quantity of foul matter from the bowels. In April she had one similar convulsion. Croton oil again relieved the bowels of masses of very foul tar-like feces.

Case II. In June, 1893, was called to case of measles in powerful blacksmith of 25 years of age. Rash slight on third day; chilly, nauseated and costive.

Calomel reduced temperature and made him more comfortable. On 9th day the eruption had faded and he was peeling on face. Bowels not moved for two days; restless in sleep; temperature 100°; no urinary disorder. Codeia was being taken for chest soreness. Suddenly he waked with delusions and for two days was furiously delirious. Whisky, bromide, chloral, morphia, and ice were all ineffectual. Magnesii sulphas was given, foul passages followed and convalescence set in at once. I had found nothing abnormal about the lungs or other organs.

WOUNDS OF THE BLADDER AND URETHRA.*

BY I. R. TRIMBLE, M. D.,
OF BALTIMORE.

Mr. President and Gentlemen : —

In injuries of the bladder and urethra we have two things to deal with. The first is the extravasated urine, if the wound has been large enough to admit of its escape. The next step is the repair of the wounded organ or organs.

The direction of the extravasated urine is influenced by the fascia in that part of the body.

A short resumé of the relations of this fascia will not be out of order.

The two layers of superficial fascia join the dartos of the scrotum, extend outward and join the superficial fascia on the sides of the thighs, run over the side of the penis and join the fascia of the abdominal wall.

It joins the rami of the pubis and ischium external to the crus penis and as far back as the tuberosity of the ischium. Posteriorly it extends down and bends over the lower edge of the transversus perinæi muscles and joins the lower margins of the deep perineal fascia or triangular ligament.

The deep perineal fascia joins the symphysis pubis and the subpubic ligament above and on each side; it joins the rami of the pubis and ischium beneath the crura penis. Its inferior border joins the central tendinous part of the perineum and looks toward the rectum. At this border it also joins the deep layer of the superficial fascia under the tranversus perinæi muscle and the thin fascia over the perineal surface of the levator ani muscle.

The deep perineal fascia is pierced by the urethra, the dorsal artery and veins of the penis and the internal pudic artery and nerve.

This fascia is composed of two layers, which are joined below, but separated above.

The anterior layer runs forward over the anterior part of the membranous portion of the urethra and is lost on the bulb of the penis. The posterior layer is derived from the pelvic fascia and runs backward around the posterior part of the membranous portion of the urethra and the outer surface of the prostate gland.

The peritoneum does not entirely cover the bladder; this organ can be injured and an opening made into it without getting into the abdominal cavity.

If the wound is in the urethra back of the triangular ligament, and the latter ligament is intact, the urine will be found deep in the pelvis around the bladder, rectum and other organs in the pelvis, and at times extending upward between the peritoneum and the posterior abdominal wall. But if the injury is in the urethra anterior to the triangular ligament, or the triangular ligament has been lacerated when the urethra was injured, the urine will then follow the superficial layers of fascia and be found in the scrotal tissue around the penis, over the abdominal walls, anterior to the muscles or on the sides of the thighs.

Injuries along the pendulous portion of the urethra are produced by external violence or the improper introduction of a sound into the canal.

When urine does escape along the pen-

*Read before the Clinical Society of Maryland, November 17th, 1893.

dulous urethra, it, as a rule, gives rise to a localized abscess which is easily dealt with by free incision of the overlying tissues.

The rent in the urethra, as a rule, heals rapidly if the surface of the wound is kept clean by hot boracic acid irrigations, and the urine is drawn off by soft catheters, the urethra being washed after each introduction of the catheter.

In wounds of the bulb of the urethra or where the penis lies along the pubic bones or under the symphysis pubis, the injury is done by a blow or a kick in the perineum or by falling or sitting heavily astride of some raised narrow object, as the pommel of a saddle, or across the top of a fence, or on the arm of a chair, or by the breaking of one of the rami of the pubic bones, or by the dislocation of the pubic bone; this brings the penis between the edge of the transverse ligament, or the pubic bones or rami of ischium. In this way the penis is crushed between two hard objects or lacerated and cut by the sharp edges of the broken bones. These bones also may lacerate the bladder or cut the urethra entirely free from the bladder.

The symptoms first following injuries of the penis and bladder bear no relation to the extent of injury done.

A patient may say he has no pain whatever, yet the bladder or urethra may be seriously lacerated.

No reliance is to be placed on what the patient says as to his condition. A diagnosis is to be made by the catheter in the urethra or bladder, and finger in the rectum or vagina.

The urethra can be severed from the bladder and the latter seriously lacerated and the only external evidence may be a few drops of blood from the meatus of the penis.

A severed urethra and bladder may present these symptoms:

The severed bladder, distended with urine, may still be connected with the urethra by some shreds of tissue, which may guide the introduced catheter properly into the bladder. The urine in such a case may escape without the presence of blood, but with the catheter in the bladder and the finger in the rectum or vagina such a condition of things would be found out at once.

If the urine is bloody there may be a lacerated bladder.

In order to see if the bladder is intact the urine should be drawn off and the bladder injected with a known quantity of warm water; this, then, should be syphoned off to see whether the same quantity returns.

Ten ounces of water in a normal bladder will make it rise out of the pelvis. The injury to the bladder walls may be a valve-like arrangement and when the bladder is full of water it will not leak, but when partially filled, its walls are flaccid, and in such a case the urine will escape.

In all cases of ruptured urethra within the perineum, perineal section should be done on sight. This is the only salvation for the patient.

The ruptured or severed portions should be found and when thought proper they can be brought together by sutures. A catheter is to be left in the proximal end of the urethra and bladder and should be allowed to protrude through the perineum.

The urethra may be sewed up and a

soft catheter left in the bladder and the distal end through the penis. But in this case the perineum must be left open. Thisprocedure is liable to set up acystitis. I would say here that the perineal incision should be a broad one and extend out to the tuberosity of the ischium, as in lateral lithotomy, to secure free drainage.

If, after doing a perineal section, the natural opening into the bladder cannot be found, a suprapubic cystotomy should be done and a sound passed from within outward until it protrudes in the perineal opening, and if thought advisable, the bladder can then be opened, as in lateral lithotomy.

If the cut surfaces of the urethra are sewed together the perineal opening must be left open.

If, after opening the bladder through the perineum, the walls are found to be lacerated, it is best to do a suprapubic cystotomy also.

If the bladder has been opened into the peritoneal cavity then a laparotomy should be done and the parts cleansed thoroughly with warm water or a normal salt solution; the tear in the bladder walls should be sewed up and a drainage tube left from the peritoneal cavity through the abdominal incision. If sloughing has taken place before seeing the patient the parts should be opened freely and when in a healthy condition something can be done if thought necessary toward remedying the deficiency.

After injuries or operation upon the urethra, sounds must be used at frequent intervals and kept up for some time; by this means the parts are kept from contracting while healing is in progress.

After the parts have healed the sounds should be used for some months or years to prevent a stricture. In the *Medical News*, of October 14, Dr. R. W. Stewart, of Pittsburg, in an article on Rupture of the Male Urethra, says: When the urethra has been severed from the bladder, it is his practice, after making the perineal incision, to perform a suprapubic operation, carrying his finger into the bladder as far as the vesical orifice of the urethra. He then passes along his finger a small steel sound in the perineal incision, fits over it a soft catheter and draws the catheter into the bladder. A sound is then passed through the penis to the perineal wound and on this the soft catheter is threaded and the sound withdrawn, establishing the catheter in position from the bladder out through the urethra. This is not removed until the following day. The cut ends of the urethra are by this means brought into position in the wound. Of his six reported cases all recovered.

Frederick Treves, in his book on Renal Surgery, of 1892, recommends in lacerated bladder to do a laparotomy, sew up the bladder and leave no drainage except through the natural channel. When necessary he uses a soft catheter to draw off the urine.

Mansell Moullin, in his Treatise on Surgery, recommends in lacerated bladder to do a laparotomy, sew up with silk, using Lembert's suture, a double row, and then close the cavity.

In extra-peritoneal rupture he advises a suprapubic operation, sewing up the rent in the bladder and leaving the opening in the abdominal wall to give free exit to the escaping urine. In ruptured urethra or one cut off from the bladder, he recom-

mends perineal incision, but does not like the retention of a catheter in the canal, as it sets up irritation and cystitis and does not prevent the escape of urine around the sides and into the tissues. He does not like sewing the cut ends of the urethra, for they may be brought together at an angle, and when they get well a stricture will remain in the urethra. It is better to keep the tract open by passing a sound every few days.

In the American Text-Book of Surgery ruptured bladder is divided into two kinds, extra- and intra-peritoneal. In intra-peritoneal, open and clean peritoneal cavity, sew up with Lembert sutures; if any peritonitis, leave drainage tubes in the abdominal cavity. If extra-peri toneal, sew up and leave drainage suprapubic or through the perineum if there is much extravasation into the perineum, vesico-rectal and vesico-vaginal connective tissue.

Injuries of the urethra are divided into three classes—mild, moderate and severe.

In mild cases, catheterization and keeping urethra clear is all that is required.

In those cases we denote as moderate, leave in a large catheter and look out for symptoms; cutting freely if any extravasation should take place. In severe injury, open freely in the perineum at once. If the proximal end of the urethra can not be found, retrograde catheterization is to be done after the suprapubic operation.

Morrow, in his Treatise on Genito-Urinary Diseases, says: "In injury to the urethra perineal incision is not to be reserved for the worst cases. It is to be applied to all, save those of the very least trivial, and it is to be done immediately after the diagnosis is made. The retention of a catheter in the urethra is bad practice."

If the urethra is severed he recommends suturing and allowing the perineal wound to remain open; an aseptic rubber tube can be left in the anterior urethra to act as a splint.

Suprapubic cystotomy will often assist the healing after suturing of the cut ends of the urethra by giving another free outlet for the urine.

Geo. R. Fowler, M. D., of Brooklyn, N. Y., in an article on Wounds of the Bladder which Enter into the Peritoneal Cavity, says: "Do a laparotomy on sight, wash out the cavity and sew up the bladder with Lembert or Czerny sutures."

Walter, an American surgeon, was the first to put this practice in use and saved his patient.

In extra-perineal infiltration do a perineal section, get rid of the urine, put in a drainage tube and have a full flow from the bottom of the bladder. Never put off this operation. Do it on sight.

In Morrow's System of Genito-Urinary Diseases we are advised that perineal section should be done immediately in all cases, except in the most trivial. This advice is supported by statistics which show that of vesico-perineal rupture 19 per cent. die, of permanent catheterization about 13.6 per cent. and of early perineal incision only 8.75 per cent. die.

I report the following cases which have occurred in my practice:

Case I.—Mr. A., age 26. In July, 1892, while waiting for a train, he attempted to sit down on a bench, but

came down on the iron railing which divided off the seats. The posterior portion of his urethra next to the triangular ligament was brought between the edge of the iron rail and the side of the ramii of ischium and pubis. The inner walls of the urethra were ruptured.

A quantity of blood escaped from the meatus; pain on pressure over the bulb of his urethra. A catheter introduced met with a slight irregularity of the calibre of his urethra.

The patient was put to bed and a careful watch kept of his perineum. The urethra was irrigated with warm boracic acid solution after each passage of urine.

The urethral wound healed in a few days and the man resumed his work in a week. A large sound is passed every three months to prevent the formation of a stricture by the contraction of the scar tissue at the point of injury.

This was a case of slight injury.

Case II.—Dec. 8, 1892, Mr. B., aged 58, while unloading a boiler from a truck, was caught between the boiler and building, and when extricated some blood was found to be escaping from the perineum. He was sent to this city, a distance of twenty-five miles, for medical aid. On December 9th, his physician called me in consultation. I found that the patient had passed no water since the accident, and there was no swelling in his perineum. He had no pain except that caused by the distended bladder. His physician had attempted to pass a soft catheter into the bladder, without success. I, however, had no trouble in inserting a hard and larger one into the bladder and extracted a quart or more of clear urine, and the bladder returned to the pelvis. I did not make an examination per rectum.

Dec. 10, A. M., met the doctor again in consultation. Had no trouble in passing the catheter. Urine clear and no blood. No swelling in perineum; no pain. Temperature 99.5, pulse 80. Bowels moved.

Dec. 10, P. M., water drawn without trouble; temperature 99.5, pulse 84.

Dec. 11, A. M., drew water from bladder; no blood; temperature 100; pulse 88; no swelling or pain anywhere.

Dec. 11, P. M., temperature 100, pulse 90; no pain or swelling. Was unable to pass catheter into the bladder; patient had had some dribbling of urine, which was slightly bloody; bladder not prominent.

Dec. 12, A. M., temperature 100, pulse 96; dribbling of bloody, dirty, brownish, offensive urine; some œdema of scrotal tissue; some pain. Operation advised. Bladder not felt above pelvis. Some peritonitis on both sides, in iliac region. Patient declined operation.

Dec. 14, consented to be operated on. Temperature 101, pulse 110. At this time scrotal tissue, perineum and sides of buttock were all involved, as was also the anterior abdominal wall.

Perineal section done. Large quantity of dirty, bloody, foul-smelling urine and pus escaped. On introduction of finger into wound, the urethra and bladder were found entirely separated. The pubic bones on both sides were broken. Pus everywhere burrowed in all directions. The bladder was opened laterally. The patient died in four days, of septicæmia.

I have given a rather full history of this case, in the treatment of which I was wrong from the beginning, a proper diagnosis not having been made. I was misled by the ease with which I passed the catheter into the bladder, the emptying of a full bladder of clear urine, the return of the distended bladder to the pelvis, the absence of any pain or swelling in the perineum, the absolute composure of the patient, statements as to his feelings and condition, etc. From a subsequent correct diagnosis, I found, however, that the patient would have had poor chances for a good recovery, even if the operation had been performed when I first saw him. He had, absolutely, no chance when it was finally done.

Case III.—May 4, 1892, Mr. C., age 28, a railroad employee, living out of the city, was, on the morning of this date, caught between the cars, the pressure being over each thigh bone. He was picked up, and with assistance walked two squares, to the station. Vomited, complained of feeling bruised and wanted to make water. Upon attempting to urinate, only a few drops of blood escaped from his perineum. A physician was summoned and assured him that he was only bruised and would be all right in a few days. He was, however, sent to Baltimore on the first train, at which I met him, and obtained the above facts. He was at once taken into the hospital of the University of Maryland, and upon introducing the catheter into the perineum, I found that it seemed to go in any direction. With the finger in the rectum, the catheter was felt free and no connection between the urethra and bladder and only the wall of the rectum between the catheter and perineum.

An anæsthetic was given and a perineal section done—a long lateral incision being made. The right pubic bone was fractured and the sharp edge had severed the urethra from the bladder. The base of the bladder had also been lacerated. The urethral opening of the bladder was found and the bladder opened as in a lateral lithotomy. The anterior wall of the bladder back of the symphysis was also cut. The large opening in the perineum gave free drainage. No possible accumulation of urine could take place in the bladder or around it.

On the sixth day a large sound was introduced into his bladder and on every second day afterwards.

The patient left the hospital well, July 1. The wounds had healed, and he returned to his work in September, 1893. During his illness his temperature did not get above 100°.

These three cases illustrate well the condition we have spoken of. The first was trivial and needed only rest and careful watching. On the first appearance of fever his perineum would have been opened.

The second was a serious case and needed operation on sight to have given the man any chance for his life.

The third was also a serious case, operated upon with a good recovery.

It has been stated that one instrument maker in New York has sold within the past year no fewer than six dozen special trusses for ventral hernia following operations for appendicitis.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD DEC. 1, 1893.

The 286th regular meeting of the Clinical Society was called to order by the President, Dr. J. Edwin Michael.

Dr. Hunter Robb read a paper on THE IMPORTANCE OF A BACTERIOLOGICAL TRAINING TO THOSE WHO WISH TO PRACTICE ASEPTIC SURGERY.

Dr. A. K. Bond read a paper entitled SOME NERVOUS EFFECTS OF DIGESTIVE DISORDERS. (See page 177.)

Dr. Bond also cited other interesting cases and said his desire had been to show that there is a group of disturbances in the sexual, mental, and sensory departments of the nervous system which are due to ofttimes obscure, sometimes unsuspected, disorders of digestion and that these often perilous disturbances, though temporarily soothed by opiates, require for permanent cure the cleansing and restoration to normal function of the digestive tract.

DISCUSSION.

Dr. David Streett: I have been very much interested in Dr. Bond's paper, but am hardly prepared to agree with him entirely. I can scarcely believe that diabetes mellitus can be brought on by indigestion, for in this disease digestion is usually good. Then, too, in the case cited in which the patient had convulsions, possibly if the urine had been examined some other cause might have been discovered. The remedy used would also have relieved a uræmic convulsion, so the diagnosis is incomplete.

Dr. R. B. Norment: I agree with Dr. Bond in believing that nervous affections are frequently due to poison absorbed in the digestive tract. If we have stomach disorders caused by mental diseases, why not nervous disturbance from stomach trouble?

I believe in uræmia as a cause of convulsions, but the simple fact that albumen is found in the urine does not prove the cause in a given case, because of the vast number of cases in which we find albumen but no kidney trouble.

Dr. J. A. Seligman: I have recently seen a case which is called to mind by this paper: A man aged 41, complaining of severe headache, pain in the back and constipation. Took a dose of castor oil and was temporarily relieved. The pain and headache returned, however, and were accompained by tenderness in right illac region and temperature of 102.2-5°. Ordered quin. sulp., gr. 5 every four hours. Next day, after having taken 30 grs. of quinine, temperature was 103°. I administered sponge bath but temperature continued up. During that day some one of his friends suggested a dose of comp. cathartic pills.

He took them, had 15 operations during the night and next morning was free of pain and temperature was 99. 2-5°. By night it was normal.

Dr. David Streett: We do frequently find albumen in urine for long periods and do not have convulsions, and also do we have Bright's disease for years without attendant convulsions.

In examining urine I consider the specific gravity of most importance. If I find a low sp. gr. with albumen, I fear convulsions, while on the other hand, if

the sp. gr. is normal the albumen alone causes me no alarm. I have never seen convulsions in an adult due to digestive troubles.

Dr. Bond: Dr. Streett agrees with me that in children we often have convulsions due to digestive trouble, then why should these influences not be reproduced in adults? The ptomaines, which are accepted as poisonous, of the nervous system, are the result of decomposition, and here is just such a condition to produce them.

In uræmia we have, we suppose, some substance in the blood which should have been excreted by the kidneys. In my cases I think we had some substance in the blood which should have been carried off by the intestinal tract.

Dr. Geo. A. Fleming: Will Dr. Bond please state how he decided that to be an epileptic and not a uræmic convulsion?

Dr. Bond: There had been no previous indications of kidney trouble, while there were positive symptoms of intestinal trouble which I consider capable of poisoning the system.

Dr. J. H. Branham: In puerperal convulsions, when death follows, kidney affection has generally been found. I fear we are liable to fix our minds on one thing as the cause of convulsions. Free purgation is a good thing, but I think it would be well to examine the urine.

Dr. J. Edwin Michael: In a matter so grave as convulsions I think you should examine everything about the patient in making diagnosis. As to distinction between epileptic and uræmic convulsions, most authorities say they are alike in character but have different causes.

H. O. Reik, M. D., Secretary.

525 N. Howard Street.

THE TREATMENT OF LOCOMOTOR ATAXIA WITH PHOSPHATIC INJECTIONS.

This method of treatment has of late been successfully used in Brussels and Geneva in advanced cases of locomotor ataxy. Dr. Forbes Winslow, in a recent communication to the *Lancet*, corroborates the reports of its efficiency and details notes of a bad case cured by injections of phosphate of sodium. The patient was seen by the late Sir Andrew Clark, who regarded the case as incurable. The injections were made in the neighborhood of the spinal column, and when twenty-five had been given marked improvement was visible, and after the fiftieth injection the patient was completely cured. Dr. Winslow states emphatically that in a certain class of cases where locomotor ataxia exists, as well as in some forms of mental disorder, absolute cures have taken place, and in cases in which the prognosis appeared grave and unfavorable. Messrs. Burroughs and Wellcome prepare tabloids which contain, we understand, ten centigrammes of the phosphate of sodium as the active ingredient.—*N. Y. Med. Jour.*

BENZOL FOR INFLUENZA.

Robertson (*Lancet*, No. 3663, p. 186) relates that he has treated a number of cases of influenza with benzol, with the best results. The drug was administered in doses of five minims every two hours and a half, in the form of an emulsion, in lemonade. As a rule, in about two hours after the first dose the general discomfort had disappeared, and within the first twenty-four hours the temperature was observed to be normal. Convalescence was usually rapid and followed by very little debility. Correspondingly good results were observed in cases of whooping-cough treated with benzol.—*Ex.*

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BALTIMORE, DECEMBER 23, 1893.

Editorial.

THE DIRECTORY FOR NURSES.

Of the numerous medical interests conducted by the physicians of this city, there is not one which is more useful in its work than the Directory for Nurses, conducted under the auspices of the Medical and Chirurgical Faculty of Maryland. This enterprise was founded some six years ago, and has since been conducted in a most successful way by a committee having it in charge. It is located in the hall of the Faculty, and is under the immediate control of the Librarian, who keeps a registration of competent nurses and furnishes the names and addresses of reliable nurses to the profession, and to the public when a call on him is made for them. A nominal charge is made for the service and the money received goes to the support of the Directory and to the Library. When one considers the importance of having at his command a reliable source from which to select a reliable male or female nurse, the value of this work can be appreciated. But aside from the value of this institution to the profession and to the public we should not overlook its indirect value to the Library of the Faculty. Already the Directory is more than self-supporting, and is annually contributing something to the support of the Library. We do not hesitate to say that if the profession gave a warm encouragement to this work it would very soon prove a profitable investment for the Faculty. This single fact should suggest the importance of aiding the committee in its good work. In Boston the Nurse's Directory, conducted under the auspices of the Boston Medical Library Association, has been developed to such proportions that the revenue received from this soruce amounts annually to over four thousand dollars. In that city both the medical profession and the public recognize the value of the trained nurse and they seek the services of such as are registered and recommended by the Nurse's Directory.

Were this policy enforced here, it would at once improve the efficiency of the nurse by guaranteeing his or her reliability and experience as a recommendation for service. It would force all reliable nurses to register at the Directory, and it would encourage all who needed this kind of labor to seek it through a trustworthy channel. In a very short time the Directory for Nurses would prove remunerative to the Faculty, and thereby enlarge the scope of work of this organization. We ask the pro-

fession to consider these facts and to give their support to the Nurse's Directory.

NEW MEDICAL LEGISLATION IN VIRGINIA.

The medical profession of our sister State, Virginia, has shown a progressive spirit in the influence it has exercised over the Legislature of their State in recent years. It has not failed to make its wants felt and it has not hesitated to ask for legislative aid in its work.

The Board of Medical Examiners proposes to go before the Legislature during the present session and ask for such modifications of the present medical law as will make the work of the Board well-nigh perfect in its legal aspects. It is proposed to reduce the membership of the Board to ten—one from each Congressional district and two homœopaths. It is also proposed to amend the law in such respects as will prevent any violation of its provisions by irregular practitioners, as was notably the case during the past year by a celebrated quack from a northern city who located in Richmond and defied the constitutionality of the law regulating the practice of medicine in Virginia.

Upon a legal technicality the quack was enabled to practice without a license from the Board of Medical Examiners. This case shows the necessity of such modifications of the present law as will prevent such evasions in future.

The medical profession of Virginia has been greatly benefited by the law now in force, as imperfect as it has been in some of its provisions. There are few States in the Union which have given such legal and moral support to the medical profession in its efforts to protect the public as has Virginia. Governor McKenney, in his recent message to the General Assembly, has urged the importance of a better law for the government of the State Board of Health. He has also suggested legislation which provides for the better treatment of the worthy sick of the State in the Virginia Hospital. It is hoped that the proposed legislation will meet with favor at the hands of the General Assembly now in session.

In view of the importance of these measures, the medical profession of Virginia should be active in urging favorable consideration by their respective representatives.

It is not safe to trust such important measures to the consideration of members of the General Assembly without a strong and vigorous effort upon the part of medical men in every section of the State.

Energetic and effective work is necessary to carry these measures through and place them on the statute books.

Medical Progress.

THE DANGERS OF CHLORAL.

The unfortunate death of Professor Tyndall through an overdose of chloral has excited wide interest and regret. Professor Tyndall was in rather poor health and suffered from insomnia. He was accustomed to take a dose of chloral at night, and a solution of sulphate of magnesia in the morning. By mistake

his wife administered the chloral solution instead of that of the salts.

When chloral was first introduced it was by far the best hypnotic which we possessed. It was very extensively used in consequence, and very soon reports of its occasional dangerous character began to come in. The profession learned to look upon it with some suspicion, and of late years one rarely hears of fatal results from its use.

A few cases have been reported of death being caused by a dose of about thirty grains. A dose of three grains has been fatal to a child one year of age. In many instances doses of fifty-five, sixty and eighty grains have produced alarming symptoms. Old people are said not to bear it so well as adults, while children bear it better; and Bouchut considers doses of fifteen to twenty-three grains safe for children of from one to three years of age. Death has occurred from a dose of forty five grains given to a child of five years.

Chloral is very often prescribed in doses of thirty and forty grains, and the danger from such doses is practically very slight in adults not debilitated by some disease. Any dose below thirty grains may be considered absolutely safe to an adult.

The amount which may sometimes be taken with impunity is very large. A case is reported (Blyth) in which a patient recovered from a dose of one ounce. A medical man, Dr. Maujot, took three drachms without any serious result.

In chloral poisoning much can be done by prompt treatment. After evacuating the contents of the stomach, strong coffee and strychnine should be given; the patient should then be wrapped in blankets and hot bottles placed about him. The temperature of the room should be raised. Lauder Brunton found that by poisoning animals with chloral, then wrapping them up and keeping them in a warm chamber, they survived doses ordinarily lethal.—*Med. Rec.*

ABSCESS OF BONE.

There is a form of suppuration in the bone which is called abscess of bone. The peculiarity of this seems to be that it is essentially a pus formation, without caries or necrosis, taking place somewhere in the medullary tissue of the bone. It generally occurs somewhat near the joints; but may be in the shafts of the long bones. Unlike the other affections of which we have spoken, it is intensely painful. The agony is great and lasting. The patient loses sleep, emaciates, has unbearable pain all the time, and there is no apparent cause for it; he will point out the location of the pain, but you cannot see any change on the outside. You may, perhaps, by taking the finger and rapping about on the bone, come upon a point where he winces every time, and says it is exquisitely painful; and you may find a slight degree of œdema. There is not much swelling, but constant acute pain, which must be distinguished from neuralgic pains, which latter may last months or years. This pain is due to the formation of a small amount of pus, rarely more than a drachm, in the bone; shut in; trying to bore its way out. It is, I suppose, comparable to the pain of felon in the hand. If this disease is recognized, a cure is quite easy and cer-

tain. Cut down upon the bone and trephine the shaft and open the medullary cavity and give exit to the pus—that is, if it is found, because sometimes after trephining you are disappointed that you do not strike directly upon pus, and have been deceived perhaps to the extent of one-half to one inch in the location of the pain. It is not exact, and you have not hit the exact spot. In this case, by taking a gimlet, or something of that kind, and boring up and down in the medullary cavity, you almost invariably strike the pus; and you are surprised to see how little there is, and are also suprised to see how absolute the relief is; and how promptly this cavity will granulate and heal up. These, if they can be recognized and treated, are an extremely satisfactory class of cases. Unfortunately, like the cases of acute diffuse periostitis, they frequently are not diagnosticated until they have produced destructive effects in the bone itself.—Dr. L. W. Cheever, in *Boston Surg. & Med. Jour.*

FOREIGN UNIVERSITY INTELLIGENCE.

Berlin.—Dr. Koeppen will deliver the lectures on Forensic Psychiatry in place of Professor Siemerling, who has accepted a chair in the University of Tubingen. —Professor Fraentzel, whose name is familiar in association with that of Professor Koch in reference to the creasote treatment of phthisis, and who is one of the most senior of the Charite physicians, has been obliged to give up both his clinical and his lecture work on account of the state of his health.

Bonn.—Professor Gustav Veit has been granted a patent of nobility. The other Prussian medical men who have been ennobled are mostly surgeons —viz., Langenbeck, Esmarch, Volkmann, Bardeeben, and Bramann, Frerichs being a physician. Professor Veit is a gynæcologist.

Iceland.—A movement has been set on foot for the establishment of a university in the island.

Innsbrück.—Dr. Georg Juffinger has been appointed Extraordinary Professor of Laryngology and Otology.

Kharkoff.—Dr. Shiltoff has been promoted to the Ordinary Professorship of Special Pathology and Therapeutics.—Dr. Bogomoloff, of St. Petersburg, has been appointed Extraordinary Professor of Medical Chemistry.

Moscow.—Mr. Mitropolski has been promoted to be Extraordinary Professor of Special Pathology and Therapeutics.

Prague (*German University.*)—Dr. Herrnheiser has been recognised as *privat-docent* in Ophthalmology.

Turieff (or *Dorpat.*)—Dr. A. Gubareff, of Moscow, has been appointed to succeed Professor Kustner in the chair of Midwifery and Gynæcology.

Vienna.—Dr. Heitler has been recommended to the Government for promotion to an Extraordinary Professorship.—Dr. J. von Wagner, of Gratz, has been appointed Professor of Mental Diseases and Neurology.—*Lancet.*

THE PATHOLOGY OF SHOCK.

M. H. Roger, in an article on Shock in the current number of Brown-Sequard's *Archives de Physiologiie,* sums up the results of his observations in the following terms: "Nervous shock is the collective series of phenomena resulting from a violent excitation of the nervous system. It is characterized by a series of inhibitory acts, one only of which is

constant and indispensable—namely, the arrest of metabolism. Shock is more common in proportion to the development and activity of the nervous system. Circumstances which augment the excitability of the nervous system, such as emotions, distress of mind, and the like, predispose to shock; those which diminish it, such as narcosis and hybernation, prevent its production or render it less serious and persistent. The determining causes of shock may be divided into two groups, according to whether they act like traumatisms and poison directly upon the nervous centres, or whether they act indirectly through the sensory nerves or the visceral nerves. From the point of view of pathological physiology shock is characterised by a series of dynamic modifications (dynamogeny or inhibition) affecting all the tissues, viscera, and secretions. The capital phenomenon is the arrest of metabolism, as a consequence of which there is a diminution in the quantity of carbonic acid gas in the venous blood, and consecutively to this troubles in calorification, respiration, and circulation occur. The treatment consists in opposing hypothermy and in favoring the production of carbonic acid gases."—*Lancet.*

THE TREATMENT OF CHRONIC GASTRIC CATARRH.

As the result of a thoughtful study of the measured effects of certain therapeutic agents, including lavage, hydrochloric acid, and intra-gastric faradization and galvanization upon the secretory and motor functions of the stomach in cases of chronic catarrh (glandular gastritis) Stewart (*Therapeutic Gazette* Nov. 15, 1893, p. 744) comes to the conclusion that in the treatment of this condition lavage is of service as a cleanser of the mucosa and as a stimulant to the most important of the gastric functions —the secretory and motor; although for all purposes but the last lavage is decidedly inferior as a remedial agent to the intra-gastric application of electricity. Hydrochloric acid, administered even in full doses, after meals, is of less value as a stimulant to the secretion of the hydro-chloric acid of the stomach than as a digestant; even in this capacity it may be of little utility in the total absence of hydrochloric acid from the gastric secretion. Under such circumstances benefit may be derived from its employment in large doses in combination with pepsin. Of the various agents employed in the treatment of gastric catarrh, by virtue of their influence upon the secretion and motility of the stomach, none is comparable with the intelligent daily use of intra-gastric faradism and galvanism.—*Med. News.*

CURETTING OF THE TRACHEA FOR THE RELIEF OF DIPHTHERIC OBSTRUCTION.

Scudder (*Boston Medical and Surgical Journal*, 1893, No. 19, vol. CXXIX. p. 465) has reported the case of a boy, four years old, in which trachetomy was performed early on account of increased difficulty in breathing. All went well until the second day after the operation, when the secretion from the tube became a little sticky and slightly diminished in amount. On the third day there was serious trouble. The secretion became still less, the respiration rapid and labored, and the child cyanosed and exhausted. All of the ordinary measures failing, a dull-wire curette

that happened to be at hand was introduced into the wound and gently carried to the bifurcation of the trachea, and all sides of the passage were systematically and thoroughly curetted. In the progress of the operation pieces of membrane, one of which made a complete cast of the circumference of the trachea, were withdrawn through the wound. The hæmorrhage was slight. The relief to the dyspnea was immediate. The tube was replaced and the child made an uninterrupted recovery. One or two additional pieces of membrane came away on the following day. The child was well and strong two years later.—*Med. News.*

THE USE OF BORIC ACID IN TYPHOID FEVER.

The *Union Medicale* for November 7th gives a *resume* of an article by Dr. L. Tortchinsky, published in the *Gazette hebdomadaire de Bordeaux.* The author used boric acid in two hundred and forty cases of typhoid fever in the course of an epidemic, and reports excellent results; only nine patients died, and they succumbed during the period of convalescence because they got out of bed too soon or committed errors in diet. The two hundred and thirty-one other patients made a rapid and complete recovery. In all the cases the patients were given a dose of castor oil with from five to ten drops of oil of turpentine. After this mixture had operated the administration of boric acid was begun, the remedy being given internally, either in powder or in solution, in doses ranging from twelve to fifteen grains for an adult three or four times a day. When there was bronchitis the boric acid was associated with expectorants and with hydrochloric acid. As a general rule, at the end of from three to five days the fever and the diarrhœa underwent a noteworthy diminution, the tympanites disappeared, the dejecta lost their odor and became normal in appearance, the urine became abundant and in every way normal, the tongue and skin grew moist, and the general condition was good. As soon as the amelioration was well marked the use of the acid was discontinued and tonics were ordered. Under the influence of this treatmeat the disease followed a favorable course, its duration was somewhat diminished, and complications were very rare. The most decided effects were obtained in cases treated early. The author has found that the effects of the boric acid treatment may be increased by combining with that drug small doses of acetanilide, quinine, naphthaline, or salol. The mixture with quinine is especially useful in the last stages of the fever, when there are ataxia, delirium, and other cerebral symptoms; it is useful also in cases of relapse. The author has never observed any harmful effect from the use of boric acid. He has also produced satisfactory results with this acid in the treatment of the summer diarrhœa of children.—*N. Y. Med. Jour.*

THE DATE OF THE INTRODUCTION OF SYPHILIS INTO EUROPE.

This subject is discussed (The *Lancet*) by Professor Binz. The conclusion he comes to is that constitutional syphilis was unknown in Europe before 1493, in which year Columbus arrived at Barcelona from Haiti and brought with him

the disease, which his followers had contracted among the Haitians. It seems that the complaint had been known and general for a very long time in Haiti and was not at all severe, but when infected upon the fresh soil of the Spanish race it raged furiously.

AMŒBÆ IN HUMAN INTESTINES.

Quincke and Roos communicate the results of investigations into the occurrence of amœbæ in human intestines. Amœbæ do not play any part in causing epidermic dysentery such as is seen among armies in the field, but are found in tropical or endemic dysentery. Two cases are described in which enteritis of long standing seem to be caused by amœbæ. In one case they were found to be pathogenic for cats when introduced into the bowel and also when the encysted form was given by the mouth. In the second case those found in the stools did not affect cats at all. Besides the already known form—A. coli Lösch v. coli felis—there is another form of amœba, amœba coli mitis, which gives rise to a milder form of enteritis and is not pathogenic for cats. Distinct from both of these is a third form—amœba intestini vulgaris—which is found in the intestines of healthy persons and is harmless. The best treatment was found to be calomel, but relapses occur, because calomel appears to favor the encysting of the amœbæ.—*Lancet.*

SUBCUTANEOUS INFUSION IN ECLAMPSIA GRAVIDARUM.

Porak (*Lancet*, No. 3658, p. 901) reports the successful treatment of a number of cases of puerperal eclampsia by means of subcutaneous injections of a saline solution. A quart of sterilized water, to which from a dram and a half to two drams of sodium chlorid have been added, and at the temperature of the body, is slowly injected into the buttock by means of a hand apparatus or a fountain syringe, and absorption is facilitated and favored by gentle massage. Of eight cases thus treated recovery took place in six. In one of the cases that terminated fatally the patient was moribund when she came under observation, and the other died at home, whither she had been taken contrary to medical advice.—*Med. News.*

FOR GASTRIC ULCER. (HEPP.)

℞.—Chloroformi . . 1.
Bismuthi subnit . . 3.
Aquæ destil. . . 150.—M.

S.—To be taken every hour or two hours.

(BOAZ.)

℞.—Argenti nitrat . . 0.03
Aquæ destil . . 120.—M.

S.—A tablespoonful three times a day on an empty stomach.—*Corr.-bl.f. Schw. Aerzte*, No. 20.

THE LATE DR. WILLIAM J. HUTCHINSON.

At a meeting of the Executive Council of the American Electro-Therapeutic Association, the following resolutions on the death of Dr. William F. Hutchinson, of Providence, R. I., were unanimously adopted:

Whereas, it becomes our painful duty to announce the death of Dr. William F. Hutchinson, one of the Foundation Fellows of the American Electro-Therapeutic Association as well as the First Vice-President of the same, and *Wheras*, in his death we lose a warm and faithful

friend, a valued associate and an accomplished member of the profession, therefore be it

Resolved: That this Association place on record the appreciation of his genial spirit, his active co operation in the work of the Association and of his deep interest in the scientific questions relative to his chosen profession.

Resolved: That we express our sincere regret and heartfelt sorrow at his death.

Resolved: That we tender to his sorrowing family an expression of our profound sympathy in their great loss.

Resolved: That a copy of these resolutions be sent to the bereaved family, to the medical journals and that they be spread upon the minutes of the Association.

Augustin H. Goelet, M. D., W. J. Morton, M. D., G. Betton Masey, M. D., Robert Newman, M. D., Charles R. Dickson, M. D., Executive Council. W. J. Herdmann, M. D., President. Marret A. Cleaves, M. D., Secretary.

POISONING BY CARBOLIC ACID.

In view of the great frequency of poisoning by carbolic acid, both accidental and suicidal, we understand the Council of the Pharmaceutical Society passed a resolution at its meeting last Wednesday to the effect that carbolic acid should be added to the schedule of poisons with the meaning of the Pharmacy Act. This important matter will, therefore, be again brought under the notice of the Privy Council, whose sanction of the recommendation is necessary before it can take effect.—*Brit. Med. Jour.*

SMALL-POX IN SCOTLAND.

For some months Scotland has been practically free from small-pox, but the disease has now broken out with considerable severity in Leith. Within the past fortnight no less than 40 cases have occurred, and the existing hospital accommodation is being taxed to its utmost. The cholera hospital is being prepared for the reception of small-pox patients, and a temporary wooden structure, to receive 40 cases, is to be proceeded with at once. Free vaccination is being adopted. As Leith is a very important shipping centre and has constant inland communication with all parts of the country, it will be necessary for the Scotch sanitary authorities to prepare themselves once more to deal with imported cases of the disease.—*London Lancet.*

NASAL CATARRH.

Professor Chas. A. W. Wilson, of St. Louis, frequently uses the following, which can be varied to suit the case:

℞.—Liq. alboline, . . . ʒ ij.
Oil eucalyptus, . . . gtt. x.
Terebene, ... ʒss.
Menthol, ... gr. v.
Oil gaultheria, q. s. to scent.

Used in compressed-air spray.—*St. Louis Clinique.*

LONGEVITY AND OVARIOTOMY.

Dr. Harris, of Philadelphia, has written to Sir Spencer Wells to inform him that there is living, and in excellent health, an unmarried lady, 81 years of age, for whom the late Dr. John L. Atlee performed ovariotomy in June, 1843, more than fifty years ago. Dr. Harris asked if this case can be paralleled in England. This was Dr. Atlee's first ovariotomy. He had 80 cases; he operated on 7 in the year he became 84

years of age; he performed tracheotomy when nearly 85, and died when nearly 86. We are indebted to Sir Spencer Wells for the interesting facts furnished by Dr. Harris.—*Brit. Med. Jour.*

DIAGNOSIS OF EPILEPSY BY THE URINE.

Dr. Gilles de la Tourrette claims that a diagnosis between hysterical epilepsy and that due to neoplasm can be made by the examination of the urine. He has found that there is an increase in the elimination of urea and phosphates during a convulsion due to a tumor, while the amounts excreted during an attack of hysterical epilepsy are diminished.—*Med. and Surg. Rep.*

FORMULÆ FOR HYPODERMIC USE.

According to Dujardin-Beaumetz, caffeine and theobromine are best administered in combination with benzoate of sodium. He recommends the following prescriptions:—

℞—Caffeine,
Benzoate of sodium, āā ℈ij.
Boiling water, . . . ℥ij.—M,

℞—Theobromine,
Benzoate of sodium, āā ℈ij.
Boiling water, . . ℥iiss.—M.

—*Therap. Gazette.*

CONCEPTION DURING THE PUERPERAL PERIOD.

Dr. Brasseur relates the case of a woman, twenty-two years of age, who was delivered on July 4, 1892, of her first child; July 8th she practiced coitus, and was again delivered March 10, 1893, of a healthy child. Calculating from the date of coitus, the second pregnancy lasted two hundred and forty-three days, that is, twenty-seven days less than the normal. This case has caused considerable discussion. Ovulation must have existed in the woman on the fourth day after the delivery, and it was necessarily quite independent of menstruation. Dr. Koenig, who actually observed the case, draws from it the following deductions: 1. A gestation period of two hundred and forty-three days after a fecundating coitus may produce a viable child. 2. The spermatozoa can live in the lochial secretions. 3. The functional activity of the ovaries is not completely suspended during pregnancy. The Graafian follicles so open that they may burst a very short time after delivery. 4. Ovulation and menstruation may occur independently of each other. 5. Among vigorous women, during the period immediately following confinement, the uterine mucous membrane may undergo a rapid regeneration which renders possible the impantation of a fecundated ovule immediately after delivery.—*Gazette Medicale de liege.* —*Med. Rec.*

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

The election to the presidency of this college was held on Thursday, December 5th, 1893. The result was as follows: Dr. Wilks received 45 votes, Dr. Reynolds 43, Sir Richard Quain 22, Dr. J. E. Pollock 12, Sir Edw. Sieveking 4, Dr. Clifford Allbut 4, Sir Wm. Roberts 3, Dr. Church 4, Sir William Broadbent 2, Sir Alfred Garrod 2, Dr. Pavy 2, Dr. Dickinson 2, and two Fellows received 1 each. A second ballot was therefore taken between Dr. Wilks and Dr. Russell Reynolds, when Dr. Reynolds received 75, and Dr. Wilks 72.

Dr. Reynolds was formally inducted to the chair by Dr. Dickson, Acting Senior Censor. Dr. Russell Reynolds, having made the usual affirmation, briefly expressed his thanks to the Fellows for having elected him to the highest office to which any member of the medical profession could aspire; and after referring to the ability and dignity with which the late President had filled all the duties of his office in a manner which he could not hope to equal, promised that no effort on his part should be spared in the performance of his honorable duties.—*British Medical Journal.*

WHOOPING COUGH.

Dr. Nageli asserts (*Dublin Jour. Med. Science*) that a paroxysm of pertussis may be aborted by drawing the lower jaw downwards and forwards; and that the course of the disease is favorably affected by suppressing the attacks. Spasmodic cough due to other causes may be similarly restrained.

FOR GRANULAR EYELIDS.

Dr. G. S. Ryerson, *Therap. Gazette*, recommends the following, applied at night (*Coll. and Clin. Rec.*):

℞—Hydrargyri oxidi. flavi., gr. iv.
Zinci oxid., . . . gr. ij.
Thymol, ... *m* ij.
Camphor, ... gr. ss.
Cocain., muriat., . gr. ij.
Vaseline, ... ʒ j.—M.

THE TOPICAL USE OF SALICYLIC ACID IN THE TREATMENT OF ACUTE ARTICULAR RHEUMATISM.

In the *Revue générale de médecine, de chirurgie et d'obstétrique* for November 8th we find an abstract on this subject by M. Bourget, published in the *Revue médicale de la Suisse romande.* The article concludes as follows:

1. The absorption of salicylic acid by the skin is rapid and very energetic. In young subjects the absorbent power of the skin is greater than in old persons, and the skin of blondes seems more permeable than that of individuls whose hair is black and whose skin is swarthy.

2. The rapidity and intensity of this cutaneous absorption always depends upon the vehicle employed to dissolve the salicylic acid. Fatty bodies are the only ones that allow of a higher degree of penetration through the skin, while with vaseline and glycerin it is far less active if it occurs at all.

3. The treatment of acute articular rheumatism with a salicylized terebinthinate ointment is very much to be recommended.

4. This ointment is less efficacious in other forms of rheumatism, but it may be used as an adjuvant to massage.

5. It has no effect in gonorrhœal rheumatism.—*N. Y. Medical Jour.*

Recommendations of Therapeutic Agents.

How to Administer Tincture of Iron.—Owing to unpleasant features, we had for some years nearly ceased to prescribe the tincture of the chloride of iron, using in place of it some other of the many ferruginous preparations. We were assured by Dr. Joseph W. Bryant, of New York, that if we would use Tarrant's Seltzer Aperient as a vehicle we would overcome the objection to tincture of iron. We have found it an immense success and almost never prescribe any other form of iron, and *never* in any other way.—*Mass. Med. Jour.*, Dec., 1893.

Medical Items.

The College of Physicians and Surgeons at Richmond, Va., has a class of 111 students.

St. Louis is to have a Saturday and Sunday Hospital Association, on the model of the London and New York Associations.

The entire medical staff of the Brazilian navy, which has been loyal up to the present time, has joined the forces of the insurgents and placed itself under the orders of Admiral Gama.

Dr. Gove, a lady physician of Greensboro, N. C., has received a temporary license to practice medicine in that State. She is the second woman licensed by the Board, the first being Dr. Annie Alexander, of Charlotte.

Professor Koch, the bacteriologist, will shortly publish an exhaustive work on an improved method of using tuberculine, and the diagnostic properties thereof. The work will also treat of the recognition of the first stages of consumption.

The vacancy upon the North Carolina Board of Health, caused by the resignation of Dr. J. A. Hodges, made necessary by his removal to Virginia, has been filled by the election of Dr. John Whitehead, of Salisbury.

A new school of medicine for women has been started at St. Petersburg, to which the State contributes 15,000 roubles annually. The course at the school lasts four years, but students are expected to work from one to three years as well, in hospitals for women and children, before presenting themselves for the final examination.

The Iowa Board of Medical Examiners has ordered that on and after July 4th, 1898, no medical school shall be considered as of "good standing," for the purposes of registration of its alumni within the State, unless it has a four-course curriculum. Each course of attendance upon medical lectures must be not less than six months long, and two courses in the same year will not be held equivalent to two courses.

The Pennsylvania State Medical Society will hold its next meeting at Gettysburg, May 15, 16, 17, and 18, 1894. Those desirous of presenting papers are requested to notify, at an early date, the Chairman or any other member of the Committee of Arrangements. Dr. E. E. Montgomery, of Philadelphia, is the chairman, and the other members of the committee are: Dr. Isaac C. Gable, of York; Dr. Geo. S. Hull, of Chambersburg; Dr. John C. Davis, of Carlisle; Dr. Henry Stewart, of Gettysburg; Dr. George Rice, of McSherrystown; Dr. E. W. Cashman, of York Springs.

The physicians of Kansas City have organized a Protective Association, numbering over three hundred of the leading practitioners of that city, for the purpose of reporting each month for general distribution among the members, of a list of those persons who are deemed able

and who do not pay their doctors' bills. These lists comprise two classes of delinquents; first, of those who do pay but "only after long years;" second, of those "who never go through that ceremony at all." Except in cases of emergency members of either of these classes will find it necessary to pay in advance.

Myopia Among College Students.—The senior class at Yale numbers 185 students; of these, 54 wear glasses, the necessity for such aids to vision having, in 25 of the cases, arisen since the students entered the College. The average age of the members of the class is twenty two.

The Organizing Committee of the Exhibition to be held in Rome in April in connection with the Eleventh International Medical Congress have decided to form an additional section, which is expected to prove exceptionally interesting. This section will comprise all kinds of antique objects—surgical instruments and appliances, and apparatus used in medicine and hygiene, statues, medals, drawings, engravings, inscriptions, etc. —relating to the practice of medicine, surgery and public and private hygiene, and to the worship of the divinity of medicine among all peoples from prehistoric times to the eighteenth century.

Information has been received by the State Medical Society of New York that many doctors who have no diplomas are practising medicine, and to get a full list of all the doctors who practise in this city the assistance of the police was requested. The captains detailed the men in districts, so that they covered the entire precinct. They were instructed to copy the names and addresses from all the doctors' signs they came across. The work was completed in about two hours. The list will be submitted to the society, which will take measures to prosecute those who are practising illegally. There are between 3,500 and 4,000 physicians in the city.—*Med. Rec.*

The doors of the new laboratory of Rush Medical College were thrown open to the students December 4. At 4 o'clock every seat in the big lecture-room of the old building was taken, and the late comers were obliged to stand in the rear of the balcony. President Edward L. Holmes called the assemblage to order and briefly stated the object of the gathering. The invocation was delivered by the Rev. Dr. J. L. Withrow, pastor of the Third Presbyterian Church. Dr. Henry M. Lyman delivered the dedicatory address. He said he remembered how the first class of the Rush Medical College had met fifty years ago yesterday in a small wooden building opposite the Sherman House. In those days little was known of the science of medicine, but the art of medicine was old and well understood and practiced. The speaker referred to the fire of 1871, and to the good judgment of the trustees in erecting the College on its present site near the big hospital. From a small institution the college had extended gradually from year to year, until now it has outgrown its clothes. Now the trustees hold $200,000 worth of property. The new laboratory which was opened he declared was equal to that of the best medical colleges.—*Jour. Amer. Med. Asso.*

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FIBROID TUMORS OF THE UTERUS.*

BY J. M. BALDY, M. D.,

Professor of Gynecology in the Philadelphia Polyclinic; Surgeon to the Gynecean Hospital; Gynecologist to the Pennsylvania Hospital.

The series of tumors I present to you to-night are interesting in that they represent most of the varieties of these tumors which we commonly meet with in practice. Clinically we recognize two varieties of this class of neoplasm—the hard variety and the soft variety. The hard variety is usually called fibroid, while the soft is known as myoma, or more correctly speaking, soft myoma, as both varieties are in reality myomata.

The soft myoma, two specimens of which I show you, is comparatively rare and is not infrequently mistaken for cysts or pregnant uteri. The first one I operated upon I had removed from the room in order that I might examine it alone, so much afraid was I that it contained a fœtus and that I had made a terrible mistake in my diagnosis.

It will be noticed that the appendages in both cases are healthy and that there has been no adhesions; such is the case with another specimen of the same kind which I have in my possession. These three are the only specimens of the soft variety that I have come across in over fifty operations for this disease. This proportion about represents the relative frequency of the two varieties.

The rest of the dozen or so specimens before you are of the hard variety of myomata, and illustrate some interesting

*Read before the Philadelphia County Medical Society, November 22, 1893.

points both as to the complications which usually accompany this disease and as to the variation in the tumors and their position. This first specimen shows the uterine cavity cut open, with a tumor as large as the fist protruding into its cavity; it represents very beautifully the variety known as sub-mucous. The interstitial variety is shown in these two specimens. All the rest are of the sub-peritoneal variety.

Again, these specimens show about the relative frequency of the three varieties, sub-mucous, interstitial, and sub-peritoneal, the latter being by far the most frequent; the majority of those which are interstitial early in their growth become pendunculated later. Of the sub-peritoneal tumors you will note that the vast majority are made up of several or more nodules, some of which are pedunculated; this again is usual and what we expect to find. The large solid tumor I hold up represents that variety of the tumor which grows into the connective tissue of the broad ligament instead of into the open abdominal cavity. It is the variety of tumor which is the terror of the surgeon.

The present specimen I attempted to remove over two years ago and ended the operation as an exploratory one, fearing to kill the patient on the table if I attempted the removal of the growth. After over two years more suffering the woman returned and demanded another trial. An increased experience and a more perfect technique carried us safely through the ordeal. Here is the tumor, and the patient is a well and happy woman. You will note that but a very small portion of the tumor is covered by peritoneum. The upper surface was the only part which was not buried in connective tissue.

There are two features worthy of note in these tumors before you. A number of them show adhesions—adhesions which existed between the tumor and the intestines, the omentum and the abdominal wall. This complication is not so very common as writers would make us believe, and yet when it does occur it is an exceedingly annoying and dangerous one when it comes to an operation.

In almost every specimen before you, it will be seen that the appendages are diseased to a greater or less extent. Many of the Fallopian tubes are distended with fluid. It is noticeable that not one of these enlarged and distended tubes is what is known as pyosalpinx or pus tubes; as a matter of fact this condition is rare. On the other hand the fluid contents are mostly serum or fluid blood. The ovaries are mostly enormously enlarged, but only in rare cases are they cystic. It is clear that the disease of the appendages is brought about by the same influences, whatever they be, which have caused the growth of the tumor.

The cause is plainly not a septic or specific infection coming from the uterine cavity or the vagina. Were that so, the tubal contents would be purulent in a large proportion of cases, many times would the ovaries contain pus, and adhesions of the appendages and tumor would occur with much greater frequency than is now the case. As a matter of fact adhesions are relatively rare, as is also pus.

Electricians have long since laid down the rule that pedunculated fibroids are not applicable to the electrical treat-

ment; in this same category they have placed all tumors of the soft variety and all of the hard variety with diseased appendages. Accepting this from their own mouths as true—and it undoubtedly is true—what proportion of these cases, the specimens of which are before you, would have been applicable to that treatment—not a single case. As a matter of practical fact about half of them had been treated by electricity without the slightest effect for good.

Surgery is the only rational treatment for these cases, and of the surgical procedures supra-vaginal amputation of the uterus is the best method of procedure. This operation is performed in two ways: either by encircling the cervix, after delivery of the tumor from the abdominal incision, with a wire nœud or a rubber ligature and keeping the stump outside the peritoneal cavity by the aid of transfixion pins; practically the same method which was originally practised in ovariotomy and which as a transition step had a certain value. The more rational and equally if not more successful method of procedure is to secure the ovarian and uterine arteries on both sides of the pelvis with ligatures, and after amputating the uterus low down on the cervix, allow the stump to retract into the pelvis; the cut edges of the peritoneum should then be brought together over the stump, thus making it practically extra-peritoneal.

The old method of not tying the uterine arteries, but of either suturing the stump with buried rows of sutures or of ligating the amputated cervix either *en masse* or by transfixion, proved to be an operation with an exceedingly bad mortality and has been abandoned. The ligation of the uterine arteries in the soft tissues of the broad ligament has been substituted and has removed all the objections and dangers of the older method of Martin, Schroeder, and other European operators.

In a paper read before the recent Pan-American Medical Congress, I reported a series of twenty-eight fibroid growths removed by the extra-peritoneal method of treatment of the stump; of this number two died. Thirteen cases were reported in that same paper as having been removed by the intra-pelvic method of treatment of the stump; of this number one died. Since writing that paper I have removed the uterus by this latter method in about fifteen cases, making in all about twenty-eight cases, without an additional death. It will be seen then that an equal number of operations by the two methods, in the same class of cases taken as they come in one's practice, good or bad, by the same operator, gives twice the mortality in the extra-peritoneal method of treating the stump that it does in the intra-pelvic method. As a matter of fact, so superior and so much more surgical is the later procedure that operators the world over, with a few exceptions, have relegated the extra-peritoneal method to the same position to which it has been relegated in ovariotomy, considering it the method of the amateur.

The will of Sir Andrew Clark, who died a few weeks ago, disposes of a property worth $1,021,000. A legacy of $2,500 is to be used in founding a medical scholarship at the London Hospital. The rest is to be distributed in the family. Sir Andrew started life as a poor boy.

GASTRO-JEJUNOSTOMY FOR MALIGNANT OBSTRUCTION OF THE PYLORUS; DEATH FROM ASTHENIA ON THE EIGHTH DAY.*

BY JOHN B. ROBERTS, A. M., M. D.

A man, aged fifty-eight years, presented himself to me with the history of having had some pain in the abdomen and some digestive disturbance for nine or ten months. About four months previously to his consulting me he had noticed a small tumor at the umbilicus, which after a time became slightly ulcerated upon the surface. The tumor on examination was about an inch in diameter and seemed to involve the entire thickness of the abdominal wall; no attachment to deeper structures could be detected. The sallow complexion of the man and his general debility led me to believe that there must be some deeper growth. Examination of the chest revealed nothing especially abnormal, and nothing of importance was detected in the urine. The fact that violent vomiting occasionally occurred led to the suspicion that there might be malignant disease of the stomach and that the umbilical tumor, which was evidently malignant, was a secondary growth. Investigation of the contents of the stomach, obtained by the use of the stomach-tube, showed an absence of hydrochloric acid in the secretion. Examination by means of the gastro-diaphane gave no evidence of any growth involving the anterior part of the stomach, for the trans-illumination seemed perfect. The vomiting of large quantities of food led me, however, to make a diagnosis that there was some pyloric obstruction.

On October 7th, 1893, the interior of the stomach was washed out thoroughly and the abdominal cavity opened for the purposes of exploration and the probable removal of the umbilical growth. Introduction of my finger revealed a tumor about the size of a woman's fist, involving the pylorus and the surrounding structures. As it was evident that the umbilical tumor was unimportant in comparison with the graver lesion of the stomach, I determined to leave the former untouched and make an anastomosis between the stomach and the jejunum. A loop of small intestine was fastened to the anterior wall of the stomach by two lines of continuous silk suture applied according to the method of Lembert. A row of interrupted sutures was then placed at the points I desired the intestinal and gastric walls to come together in front of the proposed anastomosis. These sutures were left long and the stomach and intestine held apart so as to give me room to make an incision in both organs. At the ends of the proposed apposition; no sutures were applied, as I believed I could protect the peritoneal cavity there with sponges until after the interrupted sutures in front were tied. The intestine was kept free from intestinal contents by two pieces of rubber drainage tube passed through the mesentery and loosely tied around the bowel, above and below the site of operation, so as to occlude its lumen.

The gut was then opened by an incision, two and a half inches long, made at a point opposite the mesentery and between the suture lines. The mucous

*Read before the Philadelphia County Medical Society, November 22, 1893.

coat was brought in contact with the serous coat of the bowel by whipping the edges of the intestinal wound with a continuous silk suture. The stomach was opened in the same way between the lines of suture, and its mucous and serous covering stitched together by a continuous silk suture whipping the edges. The interrupted sutures applied along the anterior portion of the apposition were then tied and reinforced with an outer continuous suture. Afterward stitches were applied at the ends of the space apposed so that there was no possibility of leakage between the approximated surfaces. The abdominal cavity was then washed with hot water, and the parietal wound brought together. A continuous catgut suture was used for the peritoneum and the skin was united with silk stitches. The umbilical tumor was allowed to remain.

The operation was a difficult one on account of the manner in which the stomach was made immovable by the size of the growth involving its pyloric end. The patient reacted well, though the shock was marked because of the length of time required by the operation. There was some vomiting for a few days, the vomited matter being sometimes dark in color and fecal in odor. At first, feeding by the rectum was employed and the stomach given entire rest. At the end of about three days smallquantities of food were administered by the stomach, and dilute hydrochloric acid given to allay the tendency to vomiting. This seemed efficacious and he took a fair quantity of whiskey, peptonized milk, beef-tea, and beef-juice, and retained these articles well. He died, however, of asthenia on the eighth day. For several days before death no vomiting had occurred and food and stimulus were taken quite freely. Strychnine and quinine were administered in the effort to keep up his strength, the quinine being give by the rectum, the strychnine by the hypodermatic method and by the stomach.

An autopsy was made a few hours after death. The abdominal incision was united superficially throughout its entire length. There was no evidence of suppuration and no redness. When the skin was pulled apart with the fingers, about a drachm of yellowish fluid was found between the peritoneum, which was united, and the skin ; and under each end of one of the sutures was a little hollow about the size of a pea in the superficial fascia. This fluid looked like pus, but was apparently lymph which had filled the space not closely brought together by sutures. The haste with which the sutures were applied because of the patient's depression caused the muscular tissues to be drawn together imperfectly. As has been said, the peritoneum was united by first intention ; and there was no evidence of septic peritonitis in any part of the abdomen. The peritoneal cavity was free from fluid, and the seat of operation was in a perfectly aseptic condition, the jejunum and stomach being well united. The great omentum was found adherent to the anterior wall of the belly in the left hypochondriac region in front of the normal omental attachment to the stomach. Behind the coil of jejunum which was attached to the stomach by the operation there was room to pass four fingers with ease. The stomach was not much dilated ; the malignant growth

occupied both anterior and posterior walls, nearly one-half the distance from the pylorus to the cardiac end.

The anastomosis had been made just beyond the diseased area in the anterior wall of the stomach. The jejunum was supposed at the time of operation to have been twisted by me so that the contents of the stomach would flow into the intestine in the direction of the fecal current. The specimen shows that this was not accomplished and that the bowel was not turned as I had supposed. The size of the growth, occupying the pyloric end of the stomach and involving contiguous structures, was about three inches in diameter and irregularly globular. Its size and the infiltration of surrounding tissues account for the difficulty found at the time of operation in bringing the stomach into the wound, although the wound was four inches in length. The omentum was adherent at one or two points along the suture line of the anastomosis on the intestine; for about four inches below the anastomosis and about eight inches above that point the jejunum was somewhat dilated. Some small malignant nodules were scattered throughout the liver, and one or two similar spots of disease were seen on the surface of the intestines. The lungs were not removed, but seemed normal except some pleural adhesions at the apex of each lung. The heart was small but was not opened. The jejunum had been united to the stomach about four inches from its upper end. The union was perfect and the amount of lymph uniting the surfaces apparently small. The superficial sutures were visible, particularly at one spot where the bond of lymph had been separated a little by the traction made during the removal of the specimen. The omentum lay behind the coil of jejunum which had been brought up to be united with the stomach. The communication from the stomach into the jejunum was found patulous, but admitted only two fingers from the stomach into the jejunum. There was no evidence of unhealthy inflammation at any point of the operative area. The edges of the opening into the stomach where the suture was used to whip the edges were united, as were the edges similarly sutured in the intestinal wall. The intestine when laid open showed that the communication between it and the stomach was satisfactorily healed on the intestinal side as it had been on the gastric side. The intestine below the seat of opening presented a congested appearance of the mucous membrane. The pyloric orifice of the stomach was contracted and surrounded by malignant masses. It would just permit the passage of the tip of my little finger, passed from the stomach into the intestine.

The most important lesson in the case is the fact that a two-and-a-half inch orifice between the stomach and jejunum had contracted in eight days so that it was only about one-and-a-half inches long and would admit but two fingers.

Society Reports.

PHILADELPHIA COUNTY MEDICAL SOCIETY.

MEETING HELD NOV. 22, 1893.

Dr. J. M. Baldy read a paper on FIBROID TUMORS OF THE UTERUS, which was then discussed. (See page 199.)

DISCUSSION.

Dr. M. Price: One of the points that I wish to speak about is the method of removal. There are in my own experience and belief but two methods that can be used with absolute safety to the greater number of patients; they are total extirpation and the extra-peritoneal method. There is another side to the question of fibroid tumor to which I should first like to call attention, and that is the question of the treatment of hard fibroid. In order to properly appreciate fibroid tumors of fibroid disease, so-called, it is well to remember that there are two almost entirely different conditions in what is called fibroid disease; in other words, the tumors are as different as day and night. When we have the hard nodular fibroid in its early development, before it has attained any great size and before pressure symptoms are present, the tumor can beyond any question of doubt be dealt with satisfactorily, its growth entirely stopped and the mass pass away, by removal of the appendages. I know of a number of cases of simple nodular fibroids without cystic or malignant degeneration where removal of the appendages has effected a cure both symptomatically and actually. If, however, the disease is permitted to go on to a later period these hard tumors are subject to many changes. Two of the most important of these are breaking down in cystiform degeneration and malignant degeneration. When the tumor has reached such a size it is not only troublesome but dangerous in several directions, and especially from pressure on other organs. It should therefore be extirpated, and the easiest and safest way is by the extra-peritoneal method with the nœud. I differ with the writer in his statement that the intra-peritoneal method has been adopted by most surgeons throughout the world. The fact is, that those who have had the largest experience, those who have probably had the most difficult operations and who advocate removal of large and complicated tumors—Mr. Bantock, of London; Mr. Keith, of Edinburgh; and several American operators who have done many hysterectomies—advocate the extra-peritoneal method or supra-pubic hysterectomy with the Kœberle nœud. They do this for many reasons. In the first place, the tumor is absolutely in the hands of the operator. Again, I differ with the writer, for I believe that there is not a tumor that ever occurred in the abdomen that cannot be removed by the extra-peritoneal method, let it be buried body and soul beneath the broad ligament. As Dr. Levis once said, there is but one principle to remember in the removal of fibroids, and that is that it is a tumor within a capsule and can be taken out whole. Any man doing an extra-peritoneal operation who leaves a particle of fibroid tissue in the abdomen has not done a clean operation. I have seen probably 125 fibroid tumors removed, and I have never seen one that could not be cleanly taken out and a nœud put beneath it. That, however, is not the way that the nœud is applied by some. They deliver the tumor to the internal os, and if a part of the tumor projects into the pelvis they throw the wire around the whole mass and leave a pedicle in the wound at least two inches in diamater. Where the tumor projects deeply you can go between the tumor

and the capsule and enucleate the whole of it, and use the capsule as a pedicle, and as the blood supply is from the capsule, save in that group of soft œdematous myomata, the patient will be absolutely safe as far as hæmorrhage is concerned, and hæmorrhage is the most important danger that we have to contend with. Nearly all the cases of death after removal of fibroid tumors reported as due to heart clot or shock are really due to hæmorrhage.

In the œdematous variety of tumors there is no other safe method except extra-peritoneal removal. When a man takes such a tumor with vessels as large as the finger and amputates at the cervix, after ligating the ovarian and uterine arteries, it is a piece of surgery which I scarcely think that he is justified in attempting. If a particle of the sheath of a myoma slips beneath the Kœberle nœud you are almost sure to have a death, and that so quick that the nurse has not time to tighten the key.

If you are going to drop the pedicle there is muscular tissue in the broad ligament, and you cannot tie sufficiently securely to say that the woman is safe. I hold that in this class of tumors there is but one operation; that is, to deliver the tumor, make a pedicle and be sure that every particle is within the nœud and that the capsule is whipped over the top of the stump.

With regard to complete extirpation, there is no question that many of these tumors can be taken out by complete extirpation down to the vagina, and if need be with vaginal drainage. This is not necessary in most cases, for ligation of the broad ligaments and ligature of one or two vessels after removal of the tumor will suffice to make the operation perfectly safe.

I have had the pleasure of removing eleven large tumors, two in pregnant women, where this nodular condition of the uterus had killed the child, and in two the nodules were rapidly becoming cancerous, and all the patients are alive. To say that a beginner can take any method save the extra-peritoneal and save his eleven cases is preposterous. Schroeder's method has been introduced and adopted throughout the country by many beginners. If they are going to do the intra-peritoneal operation it should be under the tutorage of men who have done a great deal of this work. If this operation is to be recommended to beginners or to any one, rules should be laid down by which such men can save their patients. I believe that these tumors should be removed and removed early; but I do not agree that the intra-peritoneal method is the safest and the best operation or that it is the operation of the future.

If twenty per cent. of the cases of the extra-peritoneal operation have hernia—which I do not believe—and then we operate on every one of these hernias with one, two or three per cent. mortality, we would have nothing like the mortality that the intra-peritoneal method shows in the hands of those who are doing it and who claim that it saves them from hernia. I do not believe it.

Dr. B. F. Baer: I agree in the main with what has been said of the pathology of these tumors. My experience differs somewhat regarding the symmetrical tumors referred to by the lecturer as soft myomas. On section of this character of tumor I have almost invariably found

it to be of sub-mucous variety, occupying either the anterior or posterior wall of the uterus. In only one instance of about six of this character of tumor that I have met with have I found the uterine walls uniformly enlarged.

My experience also differs somewhat from that of the lecturer as to adhesions met with in fibroid tumors. Many of the cases that I have operated upon have been firmly adherent. Especially is this true of the smaller tumors or that portion of the larger ones which occupied the pelvis. In some the adhesions have been so dense that the tumors were with difficulty dislodged from their deep pelvic attachments. Where the tumor is of good size and occupying the abdominal cavity, especially in the more symmetrical ones, adhesions have been absent, and the operation in some of the latter cases has been as simple as it was difficult in the former.

Disease of the appendages associated with fibroid tumor I think is somewhat indifferent, depending to certain extent, probably, upon the character and location of the tumor. Where the tumor is not adherent the appendages are usually free from disease, and vice versa. In the soft myomas the appendages are, as a rule, in a healthy state; but this is not uniform, for in my last case the tumor was very symmetrical, resembling in shape the pregnant uterus at about the sixth month, but in this case there was double tubo-ovarian abscess with extensive bowel adhesions. On section, this tumor was found to be sub-mucous, occupying the posterior uterine wall, the anterior wall being very thin.

I agree wholly with the reader of the paper as to the futility of medicinal treatment in this disease. I have come to believe, from a large experience, that fibroid tumor should be treated surgically, and that all other treatment is simply a waste of valuable time.

The Management of the Pedicle. As I am responsible for the introduction of a method which has caused a great deal of discusssion during the past two years, and which has been adopted by almost every operator; that is, the method which leaves the cervix entirely free and in its natural position, I feel called upon to reply to the gentleman (Dr. Price) who has just spoken. He does not seem to understand this new method, for he has confounded it with the method of Schroeder, or at least has named the Schroeder operation in comparison with the extra-peritoneal method, which he favors. By the Schroeder method, the muscular tissue of the cervix itself is ligated en masee or in sections, which makes it really intra-peritoneal. This method is faulty, and I agree with Dr. Price that if the cervix is to be encircled by a nœud it should be brought outside. The mortality by the Schroeder method was greater than that of the extra-peritoneal. But the method which I advocate is totally different in principle because it controls the hæmorrhage by ligating the bloodvessels in the broad ligaments, leaving the cervical tissue and cervical canal absolutely free, in their normal position, and covered by peritoneum, just as the uterus is covered normally.

This method of operating is much simpler and safer in every way than the extra-peritoneal. There is not any danger from hæmorrhage, as there is with both the Schroeder method and the extra-

peritoneal nœud method, because we do not depend upon constriction of the cervical tissue for control of the hæmorrhage. The same principle is applied as in amputation of the thigh, for instance, where the arteries are ligated separately. Patients have bled to death with the pedicle extra-peritoneal, because of the shrinkage of the cervical tissues in the absence of the surgeon, the nurse failing to tighten the nœud, as Dr. Price has said. This could be obviated by ligating the arteries separately, and that I should certainly do even if I were treating the pedicle outside. But why bring it outside when you can feel sure that your patient is safe after the vessels are ligated? That there is not any danger of hæmorrhage has been proven beyond question in the forty-seven cases in which I applied this method, for in not a single instance did hæmorrhage occur. Of these cases my percentage of recoveries is greater than that reported by the extra-peritoneal method. There were two deaths.

I therefore maintain sir, that if the mortality of the two methods is about equal, in the hands of operators of equal skill and experience, the treatment of the pedicle in its normal position, or, in other words, drooping it, is far preferable, because it leaves the patient in a much better condition, the convalescence is shortened, there is less suffering and less danger from hernia.

The statement that the extra-peritoneal method should be adopted because it requires less skill and experience is a weak argument, and it is not progressive in spirit.

Regarding the relative merits of supra-vaginal amputation and total extirpation, Dr. Price has defeated his own argument in the statement that he believes that total extirpation is the method that should be employed in those cases where we do not bring the pedicle outside, because the same ligatures are applied, only in greater number, when total extirpation is made, as in supra-vaginal amputation. Now the pedicle is always dropped in total extirpation; if, therefore, it is safe to treat it within the pelvis in total extirpation, it is certainly as safe to treat it similarly in the supra-vaginal operation, and is, I think, safer.

Dr. George E. Shoemaker: In the early stages of any operation, or when any great change in method is under discussion, there is always a great deal of personal prejudice involved in the opinions which are delivered. It was interesting to me to closely watch the discussion on this subject at the last meeting of the American Gynecological Society held in this city. The men who were present represented the best operators in the country, and it was evident that they were much impressed with the advantages of the new method of extirpation of fibroid tumors, and the whole trend of the discussion was in favor of the adoption of the ligation method, which we undoubtedly owe in its present form to Dr. Baer. On the other hand, there were few advocates of the extra-peritoneal clamp method and little was said about it.

I have recently seen a paper by Dr. Baldy in which he reports seventy-seven hysterectomies with seven deaths. This does not correspond with what he reported to-night, and I would like to ask him to explain a little further.

Dr. Baldy: The paper referred to includes hysterectomies done for all purposes. The paper to-night includes only those done for fibroid tumor.

Dr. Shoemaker: It seems scarcely wise to take a run of twenty-six cases with one death as a basis for estimating the mortality of any operation. A man usually has a run of a number of successes, and then two or three deaths in succession. It does not correspond with my observation that the method of extirpation by the ligature is a simple matter, or that fibroid tumors are usually met without complicating conditions which call for all the resources of surgery in their management. This observation includes cases seen in the hands of several expert operators, including the originator of the ligation method himself. The method, however, in good hands is the best so far proposed.

Dr. Ridgway Barker: I merely wish to call attention to the confusion of nomenclature with regard to the treatment of the pedicle. Dr. Baer's method is spoken of as extra-peritoneal; that of dropping the pedicle is referred to as intra-peritoneal, and that by the nœud as the extra-peritoneal. Why not speak of Dr. Baer's procedure as the sub peritoneal and where the pedicle is treated outside of the abdomen as the extra-peritoneal?

Dr. Baldy: As regards removal of the appendages. Most of the advocates of removal of the appendages are those who operate with the nœud. They can not remove small tumors with the nœud, and they fall back on removal of the appendages. Those who have done extirpation and amputation will not remove the appendages. The latter operation is as dangerous as the removal of the uterus; in some cases it is impossible. In at least one case I have been forced to do hysterectomy on account of the hæmorrhage from puncture of the veins in an attempt to do ovariotomy. The uterine and ovarian arteries furnish the blood supply to the uterus, and if they are tied securely there is no danger of hæmorrhage in removing the uterus. Dr. Price is right in the statement that this is not an operation for beginners, but after one has become expert he will adopt supravaginal amputation. In the old Schroeder method, the pedicle itself was ligated, and this we know is a dangerous procedure. Martin met the objection by whipping sutures in the stump, depending upon the number of rows of sutures and the tight tying to control the hæmorrhage. The present operation is entirely different. When you tie the ovarian and uterine arteries in the broad ligaments, hæmorrhage cannot occur. Dr. Price has destroyed his whole argument by admitting that he could do complete extirpation safely. These are the same vessels that are tied in complete extirpation. I always stitch the cervical tissue together, and then the peritoneum over the whole, making the stump extra-peritoneal. The old Schroeder and Martin operations have nothing to do with the present operation, and any criticism based upon these procedures is merely begging the question.

I am opposed to allowing fibroid tumors to remain until they produce symptoms. There is no gynecologist who does not teach removal of ovarian cysts as soon as they are found. I believe in the removal of fibroid tumors as soon as they are found. I believe that

rather than encourage delay we should encourage immediate operation. These tumors are as dangerous as ovarian cysts, and I see no reason why they should not be removed. The operation is comparatively safe. It is extremely safe for a major operation. We should remove these tumors, symptoms or no symptoms, as it is only a question of time until symptoms do appear or malignancy or breaking down occur.

Dr. John B. Roberts read a paper entitled GASTRO-JEJUNOSTOMY FOR MALIGNANT OBSTRUCTION OF THE PYLORUS; DEATH FROM ASTHENIA ON THE EIGHTH DAY. (See page 202.) The paper was then discussed as follows.

DISCUSSION.

Dr. Ernest Laplace: Senn's method, Murphy's button, and the method described by Dr. Roberts are all unsatisfactory. I have recently had made a little device which I think overcomes some of the objections to the other methods, but whether or not in practice it will prove successful I am unable to say. In the operation for hæmorrhoids with the clamp and cautery we know that if the clamp is applied transversely the tendency is toward contraction of the bowel, whereas if the clamp is applied in the long axis of the bowel the contraction of the scar tends to enlarge the calibre of the bowel. Applying the same idea to anastomosis, I have had made an instrument on the same principle as the Murphy button, but the opening made is longitudinal instead of circular, and theoretically there should not be the same tendency toward closure.

Dr. G. G. Davis: If it were simply a question of the shape of the opening, then Dr. Laplace's method might answer, but it is known that oblong openings contract as well as do circular ones. If this had been the only trouble Abbe's oblong catgut rings would have solved the problem. Murphy's button has too many objections, not the least of which is the lack of proper approximation which it gives. In Dr. Senn's latest plates the opening is made three inches long with the object of overcoming the contraction. So far as experience goes, the method of simple suture without plates is as good as any. I think that the solution of the problem lies in the direction of discovering some way by which the formation of marked scar tissue will be prevented. In a recent volume of the *Annals of Surgery,* Dr. McGraw gives a method by which a crucial incision is made in the bowel and the four corners turned up, leaving the entire opening surrounded by mucous membrane. I do not know the result of this method. It seems to me that it is in the direction of such a line of procedure that deliverance is to be looked for, rather than by any particular method of joining the surfaces.

Dr. Roberts states that he used a single row of Lembert sutures. I would ask if that is his usual custom. While a single layer of Lembert sutures absolutely correctly applied is sufficient, it is somewhat risky and does not allow for any emergency.

Dr. De Forest Willard: At the last meeting of the American Surgical Association Dr. McGraw reported the results of his experiments on dogs, where he had employed various methods with the object of overcoming this contraction after anastomosis, but in every case where the dog lived long enough there was contraction, and it was found im-

possible to maintain an opening for any length of time. He tried trap-door, stitched-back, flaps of various forms, etc., but all were unavailing.

Dr. J. M. Baldy: The opening made by the instrument described by Dr. Laplace will contract as much as a ronnd opening. It has been tried many times by various operators. Dr. Ashton and myself in our experiments found better results from the round ring than from the oblong ring. The whole matter comes to a question of how long we want to maintain the opening. In most cases the condition for which the operation is done will kill the patient in the course of five or six months.

Dr. J. C. Morris: Has the reader of the paper had any experience with erysipelas following operations for cancer? In a recent journal a number of cases of recovery from cancer after an attack of erysipelas artificially induced are detailed. A patient stated to me to-day that she had been operated on for cancer of the breast, at the University Hospital in 1885, and the day that she was about to be discharged she was seized with an attack of erysipelas. She is now perfectly healthy.

Dr. Roberts: In reply to the remarks of Dr. Morris, I would state that I have had no experience with erysipelas in cancer.

In reply to Dr. Davis, I would say that I did use a double row of sutures. I did not use rings because I regard the use of any foreign bodies as a poor makeshift and an unsurgical procedure. They do secure rapidity in operations of this nature, but in my opinion too much stress is at present laid upon rapidity of operation. The prolonged anæsthesia is perhaps the most disadvantageous factor in lengthy operations. Operative work should not be dilatory, but too great haste sometimes leads to the adoption of unsatisfactory methods.

THE DIAZO REACTION OF ERHLICH.

Dr. Julius Friedenwald says (*N. Y. Med. Journal*): My own observations, therefore, entirely confirm those of Ehrlich. In conclusion, I shall again emphasize Ehrlich's statements:

1. The diazo reaction is of great diagnostic value in typhoid fever.

2. If the case shows a slight or no reaction between the fifth and eighth days, other appearances pointing to typhoid fever, it can be looked upon at once as an exceedingly light form and the prognosis made accordingly.

3. Gastro-intestinal catarrhs accompanied by fever always run their course without a reaction.

4. Very marked and constant reactions may accompany mild forms of typhoid fever and do not justify a bad prognosis.

5. Reactions appearing continuously for a long time in phthisis pulmonalis (two months) always indicate a grave prognosis.

The Bill to Regulate Medical Practice in the State of Georgia has failed to become a law. It was defeated chiefly through the agency of eclectics. Georgia has been a particularly fertile field for cheap medical schools and cheap doctors. The State has now at least five medical schools, and in its history are the records of seven others which have lived a variable period.—*Med. Rec.*

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BALTIMORE, DECEMBER 30, 1893.

Editorial.

RETROSPECT OF THE YEAR 1893.

In looking back over the year 1893, now near its close, there are few noteworthy facts in its medical history which deserve a record. No striking discoveries have been disclosed, and no remarkable events have occurred. The professional mind has plodded through the year in its eager grasp for knowledge exhibiting its accustomed activity and industry, laboring, observing and accumulating facts. If no returns have come in the way of original gains, the sum total of knowledge has been increased by accumulated experience.

In medicine, bacteriological studies have absorbed the largest share of attention. In surgery, the abdomen has invited chief consideration. Intestinal surgery in the male and fibroid tumors in the female have enlisted the largest number of observations and discussions. Surgical literature has been conspicuous for the unusual number of contributions to these special lines of study. Intracranial surgery has not been without its triumphs and has presented much excellent work. Antiseptic surgery is on the wane, whilst the principles of aseptic surgery are being more vigorously advocated.

In materia medica and pharmacy the usual activity of the pharmaceutical laboratory has manifested itself in its influence over the various remedies introduced to professional notice. The tendency to create a clinical experience in the pharmaceutical laboratory is not an encouraging indication of progress in therapeutics. Remedies are multiplied with such rapidity that confusion ensues, and many reliable and trusted agents are pushed to the wall by the novelties crowded upon the physician's attention.

The improvement in instruments and in the armamentarium of both physician and surgeon has been very marked during the year. The inauguration of the three years' graded course of instruction by many of the medical colleges of this country, during the present year, has aroused unusual interest in the subject of medical education. The experiment so far has met with marked encouragement, and has stimulated the colleges to greater activity in methods of clinical and laboratory instruction. Already the question of a four year graded course is being pressed upon the attention of the schools which only a few years back were afraid to venture upon a three years' course.

The indications are that within a very

short time the profession and the State Medical Examining Boards will demand a four years' graded course of all schools.

Rush Medical College has very recently adopted the four year graded course, following the example of Harvard, University of Pennsylvania, and the Johns Hopkins.

There has been a decided interest upon the part of the profession in questions of medical legislation, and the legislative bodies of a number of States are being urged to pass such laws as give better control over the medical and charitable interests of their respective States. These are signs of an awakening of the professional mind in such directions as will tend to improve the status of the profession in its relations to the public welfare.

With better health laws, higher qualifications for authorityto practice medicine, with more stringent laws for the sale of drugs and food supplies, and with wiser regulation of jails, almshouses and insane asylums, no one will deny the advantages which will flow to the public. Such methods of reform inaugurated during the year 1893 should be pressed with greater vigor in the forthcoming year.

The year has been exceptionally active in literary medicine. New text-books, revised editions of old works, pamphlets, reprints and medical journals have continued to supply the professional reader with an abundance of literature. No physician with a liberal pocket-book can complain of scarcity of good reading matter in any branch of medicine or surgery.

Death has as usual removed many noted men from the ranks of the profession. Charcot, in France, and Sir Andrew Clark, in England, are notable losses sustained by the profession of the entire medical world.

The year, so disastrous to the general public in its commercial and financial operations, has proven no exception in this respect to the medical profession. Professional incomes have been cut down in many quarters and many hard-worked practitioners have experienced the trials which oppress their patrons and patients.

Whilst much suffering has fallen upon the laboring and business class, no severe epidemics have prevailed in this country, and no serious destruction of life or property has followed from storm or pestilence.

The old year goes out with encouraging indications of a more prosperous year in view. We extend to our readers the compliments of the season.

SIR ASTLEY COOPER AND HIS SURGICAL WORK.

There are few surgeons of the present day who fully recognize the value of Sir Astley Cooper's influence upon the surgery of his day.

This great man has so completely passed out of the minds of the professional worker that his life's work is almost lost to view.

In his day he exercised a controlling influence over the surgical world and since the time of John Hunter there is no surgeon who has surpassed him in industry or in the value of his contributions to surgery.

Sir William MacCormick, in the Bradshaw Lecture, recently delivered before

the Royal College of Surgeons of England, has reviewed the surgical work of this remarkable man and he has shown the debt which surgery owes to his labors and observations.

Cooper earned in his day the title of "Prince of Surgery" and his claim to this recognition has been clearly established by Sir William MacCormick. Cooper's work was done before the day of anæsthetics and before the principles of antiseptic surgery were thought of, and yet his record as an operator and observer will compare most favorably with the best work of the modern surgeon.

He excelled equally as a brilliant teacher, writer and operator, whilst his original observations in anatomy and surgical pathology opened up a new field of knowledge which his followers have profited by to a very eminent degree.

Sir Astley Cooper was born in 1768 and in early life gave little promise of the career which he subsequently reached. After entering upon the study of medicine he developed an ardent devotion for anatomical study which early led him into surgical work.

His most remarkable trait was indomitable energy, which was controlled by an honest ambition and earnest conscientiousness. His capacity for work was as striking as his zeal, and he laid the foundation for his fame by hard labor in the hospital ward and dissecting room, losing no opportunity to perfect his knowledge by demonstration and by clinical study. His rise to eminence was the natural result of intense application and of thorough study in which he perfected every detail of surgical operation. His work on the "Anatomy and Surgical Treatment of Inguinal and Congenital Hernia" was alone sufficent to establish his fame as an original observer. Cooper died in 1841 at the age of 73 and was buried in the chapel of Guy's Hospital.

His life is worthy of most careful study, as it illustrates the value of industry and of honest purpose as stepping stones to eminent position and fame.

In the study of modern surgery and of modern surgeons the professional mind should not lose sight of the work and history of men of a former generation who have made the work of the present day not only possible but more exact and more perfect.

THE NECESSITY FOR VACCINATION AND RE-VACCINATION.

Whilst no cases of small-pox have appeared in Maryland during the present winter, this disease has made its appearance in Pennsylvania and in Virginia and now prevails in a mild form in different sections of these States. In view of these facts, the Secretary of the Maryland State Board of Health urges the importance of vaccination in infants and children who have not been vaccinated. This is an important matter and should not be lightly considered by the physicians of this State. The sure way to prevent small-pox is by enforcing vaccination in every case. It is not right to wait until the disease is actually in our midst before resorting to prophylactic measures. Now is the time to institute such precautions as will make the advent of the disease impossible.

A SOCIETY OF ANÆSTHETISTS.

The frequency with which anæsthetics are now used for all manner of professional work makes the employment of anæsthetics one of the most responsible of professional duties.

In every large city anæsthetics are in daily and almost hourly use, and it goes without saying that much recklessness exists in their administration. Many of the deaths attributed to the anæsthetic agent no doubt result from the method of administration. An unwarranted prejudice has arisen against anæsthetic agents—especially chloroform—from this circumstance.

In London, a Society of Anæsthetists has recently been organized which has for its purposes a more thorough study of the physiology and practical bearings of anæsthesia.

There are a number of medical men in London whogive their time to this special feature of work and who gain a living by administering anæsthetics. That such men are more skilful in the use of anæsthetics and more trustworthy can not be disputed.

The organization of a society by such men is a most commendable movement. Practical results can scarcely fail to follow from the observations and studies of these men and their conclusions will be worth hundreds of investigations by such commissions as are instituted by the Nizim of Hyderabad. A society with a similar purpose in view should be organized in every large city.

Dr. Russell Reynolds has succeeded Sir Andrew Clark as President of the Royal College of Physicians.

Medical Progress.

THE IMPENDING REVOLUTION IN MILITARY SURGERY CAUSED BY THE NEW INFANTRY RIFLE.

In a paper on this subject (*Jour. Amer. Med. Asso.*) the following conclusions are offered by Dr. Edmund Andrews:

1. The wounds being smaller and less shattering, shock will be less and missiles will generally go through the body, and not required to be extracted.

2. The bullet being so small will have much less tendency to carry in with it patches of septic clothing and skin, and any bits that are lodged in the tract of wound will be so minute that a deep flushing of the wound with antiseptics will often sterilize the injury.

3. In cases where there is actually some chipping of a joint surface it will be possible to open the joint on the field, pick out the fragments, sterilize the cavity and close it up, thus avoiding amputation.

4. It will in future be possible to avoid a large portion of the amputations and excisions, which were formerly necessary.

5. In perforating wounds of the abdomen, the tearing of the hollow viscera will be much diminished,giving a hopeful opportunity to save life by laparotomy on the field.

6. As prompt antisepticism of the wounds will be important, the hospital corps will have to be instructed how to do it before they bring in the patient.

7. The dispersion of the wounded over wide areas will increase the difficulty of prompt "first aid."

8. Field surgery will be more scien-

tific, and require a greater variety of operations, hence the poverty ftricken little cluster of instruments formerly furnished by the Government to field surgeons must have additions adopted to the now exigencies of the battle-field.

THE USE OF SALINES IN APPENDICITIS.

Dr. Maurice H. Richardson says in *Amer. Jour. Med. Sciences:* In the mild form of appendicitis, the so-called catarrhal variety, in appendicular colics, and even in slight extravasations with localized peritonitis, salines or other cathartics may be given with safety in the majority of cases, not only in the early stages, but throughout the disease. Mild cases, however, do not require the use of cathartics; they do just as well under the opium treatment or under no treatment at all.

There is danger, occasionally, a mild case may become a fulminating one. In the latter condition, and in all cases marked by sudden violent onset, salines or other cathartics should not be used under any circumstances whatsoever. I have no doubt whatever that the exhibition of salines will cause, in many such instances, renewed and fatal extravasasations. Not only are the contents of the intestines liquefied by the use of saline cathartics, but intestinal contractions are stimulated, and if we have a considerable perforation in an appendix of large calibre, there is nothing whatever to prevent an extravasation extensive enough to infect the whole peritoneal cavity in a very few minutes. I have seen these extravasations taking place in the abdominal cavity time and again, and I have found not only the general peritoneal cavity everywhere invaded by thin fecal matter, but I have seen it pouring out of the perforated appendix. I therefore believe that cathartics should never be used in the beginning of an attack of appendicitis—that the use of opium is far more rational if anything must be used.

It is a different matter when the appendix has been removed after tying its base, or when, having drained a localized peritonitis, gauze barriers have been arranged against further extravasation; or when the disease has been going on long enough to make the adhesions strong. But not always in cases where presumably there are adhesions is it best to give cathartics until after the operation. Up to the first four or five days the adhesions which confine the septic material in a localized peritonitis are not strong, and increased pressure through the appendix caused by stimulated peristalsis may, and frequently does, rupture these adhesions and cause immediately a fatal peritonitis.

The theory of intestinal drainage seems to me a good one. I always feel encouraged when after abdominal operations the bowels begin to move freely; but in mild cases there is no danger from septic absorption, and therefore no occasion for catharsis. In general infections with an open appendix, no amount of intestinal drainage can get rid of the extravasated material, and cathartics are worse than useless. In localized peritonitis there is no immediate danger from septic absorption, there is plenty of time for surgical drainage, and cathartics may rupture the recent adhesions. Finally, with the intestinal canal intact, free catharsis is very desirable, though

certain salines cause exhausting vomit- and are often ineffectual.

TOBACCO AND THE DIPLOCOCCUS PNEUMONIÆ.

Tobacco, under certain conditions, seems to be antagonistic to the coccus of pneumonia. Dr. Welch has shown at the laboratory of the Johns Hopkins Hospital, says the *Journal of the American Medical Association*, that the action of tobacco smoke on bacteria, as the smoke is drawn through the culture tube, is inhibitory. There was formerly a medical worker in his laboratory who had always in his buccal secretions the *diplococcus pneumoniæ*, and who was able to supply the other workers with samples for cultures. But after a time this physician began to chew tobacco, and no more cultures could be got from his saliva, for the tobacco had exterminated the micro-organism.—*N. Y. Med. Jour.*

GOLDEN RULES.

Never tap a suspected renal tumor through the abdominal parietes, *i. e.*, through the peritoneum. Never think lightly of any ulcer of the tongue or lips of a patient beyond middle life. Never permit a healthy wet-nurse to suckle a syphilitic child, or child of syphilitic parents. Never neglect to warn your patient about his eyes in treating a "first" attack of gonorrhœa. Never forget many gleets are due to slight contractions of the canal and may be cured by a steel bougie.—*Med. Rec.*

OBSERVATIONS ON PERIPHERAL NEURITIS.

In the *Liverpool Medico Chirurgical Journal* Dr. Alfred W. Campbell has published a series of observations which are particularly of interest in their pathological aspect. In recent years several observers have noted in fatal cases of peripheral alcoholic neuritis changes more or less obvious in the spinal cord and even in the higher centres, so that a widely prevailing belief has arisen that the disease is really characterized by widespread changes, probably the result of a poison, occurring in the nervous system as a whole. Dr. Campbell's observations confirm such a view. He describes briefly the clinical histories of four fatal cases of alcoholic neuritis in which the diagnosis was confirmed post-mortem. One of these is of particular interest because the subject of it was a boy aged only six years and a half. Briefly, then, these cases are to be placed in the same clinical category as cases of polyneuritis alcoholica, and in all of them the nerves, muscles, and small blood vessels showed characteristic changes. All of them, moreover, presented disease of the spinal cord and medulla—viz., a scattered degeneration in all the white columns, particular strands—the columns of Goll, and Burdach and Lissauer's root zones—having suffered in a marked degree. The widespread disseminated character of the degeneration is noteworthy. In no case did the degeneration follow physiological lines, and motor and sensory columns were alike affected. The nerve roots also were not unaffected for in the cervical and dorsal regions the anterior and posterior roots on both sides were altered, while in the lumbo-sacral segments the posterior roots were more particularly degenerated. These results are definite and interesting. The changes in the cord, as Dr. Campbell supposes,

probably account for the ataxy which is sometimes present, and he is doubtless right in his contention that the widespread character of the changes and the nature of these make it likely that the alterations in different parts of the nervous system are independent of one another and are really the result of the influence of alcohol upon all parts of it.—*Lancet.*

TREATMENT OF EPILEPSY.

In the *Liverpool Medico-Chirurgical Journal* Dr. Alexander utters a word of warning against the indiscriminate use of bromides in cases of epilepsy, a warning which, we venture to say, is not unneeded. Nevertheless in the great majority of cases no other drug is so efficacious, and it is only in rare cases that it is completely contra-indicated. Dr. Alexander has observed good results from the combination of borax with bromides, especially with bromide of sodium. In twenty-six cases in which this combination was administered the fits were arrested for several months in nine cases; in seventeen they were diminished in frequency, while in one the attacks were uninfluenced, and in another they became more frequent. But perhaps the benefits of this treatment are more uniform in regard to the mental condition of the patients. Even in those who were subject to post-epileptic mental disturbance, and in others who remained dull and stupid for several days after a fit, the mental disturbances entirely disappeared. There are, however, certain drawbacks to the administration. The full dose sometimes produces gastric troubles, flatulence, and loss of appetite. But this inconvenience is usually got rid of by care in administering the drug after food, and by caution in increasing the dose gradually. Skin eruptions may also be produced, especially after continuous administration for some time. These may be accompanied by intolerable itching, but the eruptions are said to subside usually even without discontinuing the use of the drug. Loss of hair, which may be complete, is a much more serious inconvenience. Dr. Alexander's experience seems to confirm that of previous observers in regard to the efficacy of borax in certain cases of epilepsy. —*Lancet.*

Medical Items.

Dr. James E. Gibbons has removed from 833 Edmondson Avenue, to his new residence, 1102 W. Lafayette Avenue, opposite Lafayette Square.

The late Mrs. Johnson, of San Francisco, has bequeathed the sum of $6,500,000 to found a free hospital in that city. The money is in the charge of Archbishop Riogan.

The Baptists of Boston, under the leadership of Rev. Everett D. Burr and Dr. Francis F. Whittier, have determined to establish a hospital under the auspices of that denomination.

A four-year old caught a severe cold while his mother was out of the city, and on her return rushed up to her, and throwing his arms around her, cried, "Oh, mamma, both of eyes is rainin' and one of my noses won't go."—*Med. Rec.*

The Next Meeting of the American Medical Association will be held at San

Francisco, on the first Tuesday in June, 1894, instead of on the first Tuesday in May, in order to permit of a discussion of the Code by the various State Societies that meet just before the meeting of the National Association.

The prevailing despondency and stringency in medical circles might be somewhat relieved by a vigorous prevalence of the grip. Yet physicians do not anticipate its coming with any less alarm than other classes. For the grip seems to take a particular fancy to doctors, and to lay them up to a disastrous extent.—*Med. Rec.*

The late Dr. L. F. Billings. of Barre, Mass., has bequeathed his medical library and surgical instruments to the Worcester County Medical Society. On the decease of Mrs. Billings, $5,000 is bequeathed to Harvard University, to be kept as a permanent fund for the medical department, the annual income of which is to be used for scholarships for the benefit of poor but deserving medical students.

The deaths of the following distinguished members of the medical profession abroad have been announced.—Dr. Peter Antonovic Spiro, Professor of Physiology in the University of Odessa, at the age of forty-nine.—Dr. V. J. Persidski, a Moscow physician of great repute in children's diseases.—Dr. Eugenio Rivera y Reina, Professor of General Pathology in Cadiz.

Dr. Schnitzer, better known as Emin Pasha, the Governor of Eastern Soudan, having been admitted by his surviving relatives to be dead and buried in Central Africa, is to be honored by a memorial in Neissen, Germany, his natal town. In this town there now resides his only surviving sister and his little daughter, Frida. All Germany will be invited to unite in contributing to this memorial.

The Woman's and Child's Hospital, Syracuse, N. Y., took fire on December 13 from a defective flue. The patients were all got out in safety, but not without grave peril, since the weather was very cold at the time of their removal. The fire damaged the building to the extent of nearly $4,000. A large proportion of the furnishings of the hospital were saved. The losses are well covered by insurance.

A story comes from Saxony of a most attractive character. A soldier having purchased a ten-pfenning sausage, found in it the tip of a human finger-nail and bone. The vendor was brought to trial, and testified that the finger was cut off by the chopping machine and while he went to staunch the wound his assistant came in and completed the making of the sausage meat, in which he incorporated his master's finger.—*Boston Med. and Surg. Jour.*

The Medical Society of the City of Hartford, organized in 1846, is to receive a fund for the erection of a building to be devoted to its purposes and to those of the medical profession of that city. It will be in memory of the late Dr. Ebenezer Kingsbury Hunt, formerly president of the Connecticut State Medical Society, in compliance with the terms of a bequest of the late Mrs. Mary C. Hunt, of Hartford, widow of the late

Dr. Hunt. The medical school at Yale University will also fall heir to the sum of $25,000 under the will of Mrs. Hunt.

The first annual meeting of the American Medical Publishers' Association was held in Cincinnati, on Monday, December 4, 1893. The by-laws and rules were revised and amended, while the name was modified in accordance with a demand from medical publishers of a general nature who desired to become members of the Association. The active co-operation of every medical publisher is earnestly solicited. Next meeting in Washington, D. C., September, 1894. Officers: President, Dr. Landon B. Edwards, Richmond, Va.; Vice-President, Dr. J. C. Culbertson, Cincinnati, Ohio; Treasurer, J. MacDonald, Jr., New York City.

The Director of the Chicago Pasteur Institute has issued a circular, dated November 18th, giving the results of the preventive inoculations against hydrophobia practised in this institution since its opening on July 2nd, 1890. Three hundred and two persons have been treated, classified as follows: 104 bitten by animals proved to be rabid by the results of experimental inoculation or by the death of other persons or animals bitten by the same animal; 126 bitten by animals recognized to be rabid by the symptoms of the disease during life; 72 bitten by animals strongly suspected to be rabid; 282 were bitten by dogs, 7 by horses, 7 by cats, 3 by skunks, 2 by wolves, and 1 by a mule. One death was reported among the patients treated, thus giving a mortality of only 0.33 per cent.

Dr. Stellwag von Carion, the *doyen* of German ophthalmologists, proposes to retire from his professorship at the termination of the current semester. Drs. Kaposi and Neumann, who have for many years been Extraordinary Professors of Dermatology and Syphilis, have been raised to the rank of Ordinary Professor. Some excitement has been caused amongst the students by the alleged severity of the examinations in midwifery, though it is stated that only 13 per cent. of the candidates were rejected. Complaints are made that the number of students in the two obstetric clinics is too great, and it is hoped that a third clinic may be established for them, whilst it is expected that two sessions' attendance on this subject will be required instead of one only as at present. —*Lancet.*

Glanders is becoming so prevalent among the human population of Cuba, that a commission as been appointed to devise measures for the repression of the disease. According to the *Cronica Medico Quirurgica de la Habana*, glanders was imported into Cuba from the United States during the insurrection of 1868, and ever since it has been largely prevalent among horses throughout the island. The first case in the human subject occurred in 1870, and since then from twenty to forty persons have died of the disease every year. One of the most recent victims was Dr. José Francisco Arango, a brilliant physician and teacher, distinguished for his literary not less than for his scientific attainments. By a melancholy coincidence, the first case of glanders in the human subject which occurred in Cuba was reported by him.

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THE THERAPEUTICS OF SUGGESTION.

BY GEORGE J. PRESTON, M. D.,

Professor of Physiology and Diseases of the Nervous System, College of Physicians and Surgeons, Baltimore.

A very interesting chapter in the history of medicine is that which relates to the subject of hypnotism. The antiquity of hypnotism is very great, undoubted instances of induced hypnosis being met with among the earliest writers. In the early times it was supposed to be a special act of the gods, and was practised as a priestly function. After having posed for many ages as a manifestation of the power of the gods, hypnotism and the hypnotic state gradually came to be regarded as a diabolic possession. Still later it passed through the phases of mysticism and witchcraft, until at the present day it is by many intelligent persons regarded in the light of a clever trick. There can of course be no doubt of the genuineness of the phenomena of hypnotism—the only points of dispute are the nature of these phenomena and the extent to which they may be employed for the cure of disease. Every decade or so the study of hypnotism is taken up with ardor, pursued for a time and laid aside, to be again revived after a lapse of another ten or twenty years. Each period of aroused attention has done something to elucidate the mystery which hangs around this interesting psychological state, though we are still far from clearly understanding it. Careful study of any subject is never valueless, and

the good work that has been done on the subject of hypnotism by so many eminent workers, particularly the work of the French school during the last decade, has had this result, if no other: that marked emphasis has been given to the value of suggestion as a therapeutic agent. Attention has especially been directed to this subject by M. Charcot, who has clearly shown that certain phenomena which were regarded by Bernheim, Luys and others as part of the hypnotic state, are due entirely to suggestion and are entirely under the control of the operator. Charcot has gone further and has shown how remarkably susceptible many persons, especially hysterical subjects, are to suggestion, even when not in the hypnotic state. No physician, or even layman, need be reminded of the potency of suggestion. We all know how powerfully mental states act and react upon physical conditions. A story is told of a certain physician full of zeal for science who, on his morning rounds, left some inactive powder with all his patients, and later in the day sent his boy around to all the houses to say that he had given a powerful emetic by mistake. As a result more than half of the persons thus tested vomited. Dr. John Makenzie produced a violent attack of "rose cold" in one of his patients by showing her an artificial rose. Every physician is familiar with the virtue of water used hyperdermatically and of bread pills given at frequent intervals. Any candid physician will admit that a very large proportion of the prescriptions he writes owe their efficacy to mental impression—to suggestion.

The ill effects of suggestion are perhaps more noticeable than are the good. The faintest suggestion to many women that there may be something the matter with her reproductive organs so fixes itself in her mind that she does not rest until some operation has been performed. The evil effects of this particular suggestion must be familiar enough to all general practitioners; it certainly is to the neurologist. The explanation of the peculiar potency of this particular suggestion is to be found in the mystery which attaches itself to the lay idea of reproduction and the intimate relationship existing between the higher and lower centers presiding over this important function. Physicians rather hesitate to make full use of suggestion, because it has a flavor of chicanery, charlatans, faith cure, mind cure and the like, yet this is simply the old argument of use and abuse. It would seem at first sight to be utterly unscientific, and yet if we look at it from the psychological side it is most highly scientific, involving as it does the most subtle questions. Of course it is not intended to imply that physicians do not make use of suggestion, for they do use it every day of their lives; but the aim of this paper is to show the class of cases in which we can expect good results from the application of suggestion, and the manner of using it. As was noted above, Charcot has shown that it is particularly in the case of hysterical subjects that suggestion is most effective. We have the hypnotized subject entirely at our mercy, and any suggestion, however absurd, is gravely received and acted upon. In like manner we can make suggestion go very far with hysterical subjects. They are to a certain extent willing to let some person

in whom they have or seem to have great confidence determine in great part their mode of thought and action. It may be said in passing that this confidence is reposed without any reason, and very often unworthily. In addition to this class there is a large class of neurotic individuals who are not distinctly hysterical, with whom suggestion is potent. In a word, the cases that are meant are those in whom the higher centers are involved. These higher centers, wherever they may be located (the fore brain probably) are functionally inactive. They can no longer act either as recipient or as originating centers. In the one case the recipient center being temporarily out of function, afferent impressions are meaningless, and we have various disturbances of sensation, varying from hyperæsthesia to anæsthesia. The afferent impressions are either not perceived or they are misinterpreted. In the second case the higher center is no longer able to act voluntarily upon the cortical motor area and the result is a functional motor paralysis. It is quite a supposable hypothesis that the protoplasm of the cells composing the higher centers has been more or less used up and hence the cell is out of working order, just as the protoplasm of the cells of the posterior root ganglion is vacuolated and used up by continuous stimulation artificially induced by means of the electric current. (Hodge.) Theoretically we should expect some purely psychical cause to bring about this condition of the cells, whose function is a psychical one—such causes as grief, worry, care, responsibility, and emotional excitement long continued or very intense. Practically we see these very causes most potent in the production of the condition under consideration, which may be pure hysteria, hypochondria, general nervousness, neurasthenia, and the like. In regard to these various conditions it may be said that it is far more common to find them combined than separate and distinct. We see evidences of hysteria in most of them, though the fundamental condition may be neurasthenia, hypochondria, and the like. The close relationship which exists between these different affections make it often well nigh impossible to differentiate clearly between them. The similarity between these morbid mental states—hysteria, hypochondria, neurasthenia, and the like—and their very constant association, constitutes, to my mind, an additional argument in favor of the view which regards them all as involving to a greater or less degree the higher brain centers.

In the treatment of these cases there is a point where treatment by means of drugs, including the general hygienic measures which are so important, altogether fails. I would not for a moment underestimate the great importance of certain medicinal agents and especially of such general measures as exercise, rest, forced feeding, the hot and cold douche, and the like, together with electricity and massage, but I especially wish to emphasize the fact that these measures alone are not enough. We have most emphatically to "minister to a mind diseased," and it is here that suggestion plays its important role. We know that the changes that have taken place in the brain, if indeed there have been any changes in structure, are functional in

character. It may be, as has been stated, that the protoplasm of the brain cells has been used up, but we know from experiment that this is a physiological process carried a step too far and that rest brings reparation. Seeing, then, that we are called upon to treat an affection of the higher centres, we seek for some means of acting upon these centers. We know that in many cases all that is needed is to start the centers into activity and they will gradually take up and carry on their normal and natural work. An illustration of this is be found in the sudden cure of hysterical affections. The difficulty lies in applying the proper kind of stimulus. We cannot always contrive to have a house burn down to cure hysterical paralysis, to furnish as needed some intense emotional shock to arouse the hypochondriac, nor compel neurasthenics to perform manual labor in the open air. We know, however, that we can act powerfully upon the psychical centers by means of suggestion properly applied. Suggestion will be found useful for two purposes; first, as a means of diagnosis; and second, as a means of cure. It very often happens that we are not certain and have no means of arriving at certainty as to the hysterical nature of a given condition. This is particularly true of subjective symptoms.

A patient complains of pain at some point where we might reasonably expect a neuralgic or rheumatic pain. There is no way of deciding whether this pain be genuine or not, unless the patient is under observation for some time. Now it is often possible to convince oneself of the hysterical nature of the affection by means of suggestion. In cases of hysterical contracture and paralysis, where it is not desirable to use an anæsthetic, suggestion is most valuable. As illustrative of these two points the following examples may be cited : a patient in one of my wards at the City Hospital complained of most intense pain in his shoulder; there was no evidence of rheumatism and the diagnosis lay between neuralgia and hysteria. By a series of suggestions, I was able to move the pain to another part of the body and diminish its intensity. Of course the element of willful deception must be excluded. One must bear in mind the possibility of "suggesting away" a genuine pain, since it is entirely possible to temporarily relieve a genuine pain in susceptible persons by means of suggestion. Another illustration is the case of a young girl, who was under my care for some time, with a contracture of the knee joint, the leg being flexed strongly on the thigh, and the thigh on the abdomen. This condition has existed for several years, and had been pronounced by several physicians to be disease of the joints. A few moments of vigorous suggestion enabled me to straighten the limb perfectly. Of course the negative value of suggestion is not great, for one sees many hysterical conditions that unfortunately do not yield to suggestion. Still, this method is often of great value in differential diagnosis.

The method of applying suggestion requires careful consideration, since each case must be studied by itself. One should not expect success if the same sort of suggestion be made to an ignorant servant girl, and to an educated, refined woman. In the former case the most important element of the suggestion is

its intensity or imperiousness ; while in the latter there must a more distinct appeal to reason. Anyone who is familiar with the phenomena of hypnotism knows that there is no limit to the power of suggestion in the hypnotic state; all that is needed is the imagination of the hypnotiser. The most improbable and absurd statements are received and acted upon as facts.

In applying suggestion in the non-hypnotic state it is necessary to maintain a show of cause and effect—there must be something to hang the suggestion on. It is very necessary to employ "means" which must be as impressive as possible. The old Prophet might command his patient to "go wash in the river Jordan," but the modern physician must use some more striking remedy.

A mistake that is often made in the treatment of these cases (hysteria and the general class of functional nervous disorders) is telling the patient that there is nothing the matter and urging him or her to exert the will power. The patient knows full well that there is something the matter, and knows equally well that the very thing that is seemingly impossible is to exert any degree of self control. Our aim is to build up and strengthen this exhausted will power; to find some means of exercising it as we exercise an atrophied muscle. I would not be taken as belittleing the well known therapeutic measures, such as forced feeding, isolation, massage, electricity and so-forth. These measures constitute in most cases the important and fundamental part of the treatment.

Each one of these measures has its place and is directed to meet some indication, but we are apt to neglect the part played by suggestion even in the very application of these remedies.

Weir Mitchell probably intentionally made that form of treatment known by his name as suggestive as possible. Nothing could exceed it in suggestiveness—the isolation, the frequent feeding massage, electricity, the various hydrotherapeutic measures employed, and the martial strictness with which all directions are to be carried out. Any one who has ever tried this mode of treatment knows how futile it is unless the patient is willing to submit perfectly and absolutely to the commands of the physician and nurse.

Hence it is important to make the suggestion as strong as possible. The patient must be ordered to carry out the prescribed regimen with the utmost regularity and exactness. Then the suggestion daily, or every few days, that there is some improvement, is very necessary. This should not be made in a vague general way or it will have no effect. Each symptom should be carefully watched and the least improvement pointed out and hailed with delight, as the beginning fulfilment of the prophecy. The more one sees of this class of cases, the stronger grows the conviction that the individuality of each case must be carefully studied. General rules of treatment will not avail, and general directions to the patient or nurse are worse than useless. It is the insistance upon minute and specific details that makes the treatment efficacious, and the explanation of this is, I think, that in this way the treatment is rendered far more suggestive.

One of the most potent agents in sug-

gestive therapeutics is electricity. I must make the same reservation in regard to electricity that I have made when speaking of the other means used in the treatment of the diseases under consideration, namely, that apart from its real value it possesses a very high suggestive value. In the treatment of certain purely hysterical affections, as hysterical aphonia, contracture, anæsthesia and the like, there is nothing to compare to the Faradic current properly used. In those vague conditions of spinal pain or unnatural sensations about the head, the galvanic current is very useful. The applications should be made daily or every other day, and the strength of the current should be sufficient for the patient to distinctly perceive it. The interrupted galvanic current fulfils these indications admirably. In applying the current to the head a moderately weak current should be employed, say 5 to 10 M. Of course we know that very many cases of genuine neuralgia in which there is not a trace of hysteria will often be cured in a few moments by the galvanic current, but of these cases we are not speaking —only of the cases in which we have the purely neurotic element to deal with. By far the most suggestive form of electricity is the static, for the patient has the visible mystic fluid in the form of a spark, before the eyes, and the paraphernalia of the machine contributes its important part. Exercise can be made very suggestive by prescribing it in definite doses. The patient complains of not being able to walk any distance without great fatigue. Make the first walk only one square, or even less, ask minutely the effect produced, and in a day or two increase the walk to twice the distance. In this way the will power of the patient is gradually strengthened and after a while exercise ad libitum may be ordered. In the same way the use of water may be made very suggestive. Great complaint will often be made of the cold douche, and the temperature can be raised and then lowered to the point desired. It is often necessary to be firm even to the point of harshness with a great many patients. On the other hand, some patients must be humored; the decision as to which method is to be employed depending upon the individual case.

Many of these patients complain of dyspepsia which does often exist, but which more frequently is only another manifestation of the disordered mental state.

If regulation of diet and simple remedies are not successful, one or two washings of the stomach with the stomach tube will generally bring about a cure. The rule to be always followed, a rule that the quack knows only too well, is to make the treatment as impressive as possible. It is the higher centers that are involved, in these cases under consideration, and it is toward them that our treatment must be directed; we must endeavor to stimulate these centers, and then allow them to work out their own cure. There are two conclusions to be drawn from the foregoing remarks, namely: first, in the treatment of hysterical, hypochondriacal, neurasthenic, and the like conditions, one of the most if not the most important agents in our hands is suggestion properly employed. Second: it is most important that the physician should not himself be deceived and give

the credit to drugs that properly belongs to suggestion. The first statement has been sufficiently elaborated; the second requires a few words of explanation.

Most physicians, as has been stated above, recognize that in the treatment of the lesser ailments medicines are rarely used to the point of physiological action, and that the good results that follow their use must necessarily be for the most part due to the mental effect produced by the administration of such drugs. In the treatment of all slight ailments, the physician may truly say that it makes no difference whether the good result is brought about by the medicine directly, or by the intervention of suggestion. It is where serious and dangerous measures are resorted to that this self-deception becomes truly dangerous. Many examples might be taken to illustrate this point, but I will select one only which is the most glaring.

As has been said, most neurotic women are anxious to ascribe all their ills to some disease of the reproductive organs, and if it is not going too far it seems to me that many gynæcologists have been led into this same error. More than this, they have been strengthened in their false position by the fact that apparent cures are often wrought by an operation upon a purely neurotic woman. The profound mental impression which is made upon the mind of a neurotic woman by the formidable operation of removal of the ovaries, the fact that she can no longer bear children, or that she is separated in a manner from her sex, the more or less prolonged rest in bed, the care that is bestowed upon her—all these things cure her temporarily and it would be wonderful if such a result did not follow. Here we have suggestion in its most potent form. As a matter of fact—and I think nearly all neurologists and many gynæcologists will bear me out in this—ovariotomy performed for the relief of purely neurotic symptoms, the organs themselves being healthy, rarely if ever effects a permanent cure. Many of our leading gynæcologists have adopted a rule which all should follow, which is never to remove the ovaries for purely neurotic symptoms, unless, of course, there exists gross disease of these organs. There may be cases now and then in which the symptoms seem closely connected with the monthly periods, in which all other treatment has failed and the symptoms are severe enough to warrant the experiment of producing an artificial menopause, but even in such extreme cases as these the chances of cure are small. The operation, as has been said, is unfortunately often successful for a time as a result of the mental impression produced, but the old symptoms recur after longer or shorter intervals, and in some instances are aggravated. In these cases, where the patient is laboring under the delusion that the ovaries or uterus are affected, it is a very simple matter to make a suggestive treatment by means of the battery or in some other way, and in many instances the results are just as permanent. I recall a case in which ovariotomy was done for the relief of purely neurotic symptoms and the girl was cured for a few months, when the same old symptoms returned and electric treatment had the same happy effect, as it doubtless would have had in the first instance.

There can be no doubt, I think, that in the near future these cases of which I

have been speaking will be studied from their psychological side and treated accordingly. Some of them can be best treated by means of hypnotism, but by far the greater number must be treated by some plan which has for its basis the idea of suggestion.

CLEFT OF THE HARD AND SOFT PALATES.*

BY J. EWING MEARS, M. D.

An experience extending over twenty-five years, in which time I have treated by operative procedures upward of one hundred cases of deformities of the palate, has afforded me an opportunity to study the conditions involved, the measures for relief, and the value of the results obtained. The cases under treatment have included all forms, I believe, of congenital and acquired cleft—deformity limited to the soft palate, partial and complete in its extent; of the hard palate—partial and complete, including involvement of intermaxillary bone, and the upper lip, with either single or double cleft. With regard to the cleft of the soft palate, I have observed that in nearly all cases of complete cleft there has coexisted a cleft in the hard palate, implicating to a slight extent the horizontal plates of the palate bone. I soon learned that this condition had an important relation to the success obtained in effecting closure, and I shall refer to it when discussing operative measures.

Of acquired cleft I have met with various forms—from simple perforation, by a small opening, to almost entire obliteration of the soft and hard palates, with destruction of portion of the osseous structures of the nasal cavities. In one instance there was not only a fissure in the median line, but the lateral portions were united by firm adhesion to the posterior wall of the pharynx.

In congenital cleft of the hard palate I have met with instances in which the fissure being bilateral there has been more or less deficiency of the vomer, and in other cases the fissure being limited largely to one side, the vomer, somewhat deflected, has been found in articulation with the side less involved, thus permitting communication between one nasal fossa and the oral cavity only.

In the study of the cases under treatment I have been interested in arriving at satisfactory conclusions as to the causes concerned in the production of the deformity, and to what extent hereditation and maternal impressions take part. During the summer of 1876 a lady from the far West came to my office for consultation. As soon as she addressed me I thought I recognized, by the nasal articulation and gutteral tone of voice, a cleft of the palate, and remarked: "I know why you have come to me for consultation; you have a cleft palate." She replied: "I have not, but I have the articulation of one having a cleft palate, and I have come to you for relief." On examinatien, I found there existed a marked shortening and rigidity of the soft palate which prevented its contact with the posterior wall of the pharynx and thus led to the production of the nasal tone of voice. By division of the tensor palati and the palatoglossi and pharyngei muscles I relieved the tense condition of the velum and secured its elevation so that it approached quite nearly in contact with the poste-

*Read before the Philadelphia Academy of Surgery, Nov. 6, 1893.

rior wall of the pharynx and very materially improved the articulation. The patient had recently married. A few years after she brought to me her first-born child, which had a complete cleft of the soft, with partial cleft of the hard palate, upon whom I operated with good success.

A man, upward of fifty years, consulted me for cleft of the soft palate, the result of diphtheritic inflammation when a child. His mother dying during his childhood, his father married a second time, and he was the victim of a step-mother's jeers, as well as of her cruelty, on account of his unfortunate condition. Daily she would imitate his tone of voice. Her first child by the victim's father had cleft of the palate. Other instances I have met with in which the mother attributed the condition in the child to having conversed with a person who suffered from cleft palate, etc.

Whatever causal effect hereditation and maternal impressions may have, the observations made in the Dublin Zoölogical Gardens some years since in the case of lion whelps, have quite positively determined that the condition may be due to a want of proper nutrition in the mother during the period of gestation. Up to the time referred to it had been impossible for the authorities in charge of the garden to rear the young of the lion on account of the universal occurrence of cleft of the palate, which prevented the taking of nourishment to maintain life. The plan of giving to the mother during pregnancy ground bone and food containing the inorganic elements of bone was crowned with success, and within the past years a large revenue has been derived from the sale, to all parts of the world, of lions raised in this garden. The lion's whelps in the Zoölogical Gardens of Philadelphia have suffered in the same manner, and I have suggested to the Superintendent to adopt the plan practised in the Dublin Garden. During our conversation he stated an interesting fact, that the whelps of lions in traveling menageries did not suffer as those born of mothers confined in gardens, and he was disposed to account for the fact by the rough life led by them, as well as by the variety in the food, consisting of bones as well as of meat—sometimes more of the former than of the latter.

The conclusions which may be drawn from the consideration of the above observation are to the effect that the fissures are due to a want of coalescence of the palatal processes and embryonic tissues during embryonic life, the absence of which union is not due to an infolding or reduplication of the membranes, but to a positive non-development caused by want of proper nutrition. Coalescence cannot take place because the parts are not in approximation.

The conditions presented by persons the subjects of cleft palate, are defective articulation, deglutition, and, as a rule, more or less chronic inflammation of the nasal and pharyngeal spaces. These conditions vary in degree in accord with the extent of the lesion, but I have observed as great an involvement of articulation where a slight notch only existed in the uvula as where both soft and hard palates have been fissured. The important function of the velum is, by its approximation to the posterior wall of the pharynx, to shut off the cavity of the

mouth from the cavity of the nose, so as to prevent the passage of sounds and of food into the latter during articulation and deglutition. The muscles of the velum control by their action the opening and closing of the posterior nasal apertures, as those connected with the nasal cartilages regulate the opening and closing of the anterior nasal apertures. In cases of palate fissure in adults I have observed the use made by the anterior muscles in the effort to do the duty of the velum in so narrowing or contracting the anterior nasal openings as to prevent the escape of sounds or food. The chronic inflammation which exists in cases, as a rule, of extensive fissure, is due to the exposure of the parts to the effect of the air which comes directly in contact with the surfaces without passing through the recesses of the normal nasal fossæ.

The object to be accomplished by treatment is to close the clefts. This can be done either by the adaptation of artificial appliances—obturators—or by operative procedures—staphylorrhaphy, when upon the soft palate; uranoplasty, when upon the hard palate. Since the introduction of these methods each has had its period of employment. Discouraged by the failures to obtain perfect results by operation, artificial appliances came into vogue and were employed to the exclusion of operative measures. These failing to satisfy the requirements and especially failing to give comfort to the patient, lost favor and a revival of operative methods has occurred. In my experience I have never found the use of the obturator in cleft of the soft palate satisfactory. In cleft of the hard palate alone I have frequently advised its employment, where the rudimentary palatal processes have been so narrow as to forbid operation, or where the opening was not very large. In some cases in adults of cleft of soft and hard palates, I have closed the soft palate by operation and had adapted to the opening in the hard palate an obturator. In children, I always advise closure by operation.

I have operated at various periods of life—from three years to fifty. I advise operation at an early age in order that the growth of the parts may be facilitated, and that the education of the child may receive proper attention. In children and young persons, especially in females, I used an anæsthetic agent—a mixture of chloroform one part to ether two parts; the patient is placed or held in a sitting or semi-recumbent position. The mouth is held open by a gag which I devised and which has proven satisfactory, easy to introduce, readily held in place, and one which can be quickly removed. In paring the edges of the cleft I secure as large a raw surface as possible in order that the union may be strong. I have tried many forms of needles and varieties of sutures, and I have found the simplest the best. The instrument employed consists of a handle to which needles of various curves can be securely fastened. Silver-wire sutures of medium size are used, a strong linen thread, double, being first deposited and the wire suture hooked into the loop and drawn through ; the suture is deposited on one side at a time. The needle is introduced some distance from the edge so as to include a sufficient amount of the tissue to hold the edges firmly in apposition without tension. When the sutures are all in position the edges are

brought together and the muscles divided, which may be necessary to relieve all tension. The tensor palati is divided near to the hamular process, and the palato glossi and palato-pharyngei as low down as they can be reached. In my later operations I have removed the sutures earlier, beginning on the fifth or sixth day to remove those affording the least support and completing removal by the seventh day. This plan has given better results. Liquid food, milk chiefly, is administered by a spoon, whilst the sutures are in position. The patient gradually returns to the use of solid food.

In operation upon the hard palate the method of Sir William Ferguson has been latterly employed, having failed by other methods to secure good results. The steps of the operation consist in freshening the edges, depositing the sutures through openings made with the drill in the bony processes, divison of the processes by the chisel or saw, drawing of the segments thus formed to the middle line, and securing them in place by twisting or shotting the wire. The section of the bone should he made so as to avoid wounding the vessels and nerves which come into the oral cavity through the posterier palatine canals, and which lie in a groove at the base of the alvelor process. Division of the soft palate downward is necessary to bring the segments in position without undue tension. The cavities formed by the transplantation of the segments are plugged with iodoform gauze, 5 per cent., which affords support and controls hæmorrhage. On the third day the plug is removed, and as the spaces close they are gradually reduced in size.

End results. As to operative procedures on the soft palate. If careful examination has been made to detect slight notch in the hard palate and the bone has been divided, union in entire extent has occurred. In cases of long uvulas non-union has sometimes occurred at the very tip. This has been remedied by subsequent operation on the end ; if the length permits, cut off.

As to the hard palate. In certain cases slight necrosis of portions of the segments, caused by splintering at the time of section, has occurred and the pieces removed. This has not interfered with the reparative processs. In one instance the space on one side, left after drawing segments to the median line, was so large that it did not close completely—an obturator was successfully adapted.

As to the restoration of function. In all cases deglutition has been markedly improved, rendered perfect except in a few instances of short and rigid vela in which hasty and careless efforts at swallowing are accompanied by the passage, especially of liquids, into the nasal cavities.

The improvement in articulation has varied greatly and the improvement has depended largely upon the size and conformation of the faucial and pharyngeal spaces. In a few it has been complete. I can recall at this time a lad who had complete cleft of palate, alveolar process, and upper lip. In infancy the cleft of the lip was closed by Professor S. D. Gross. At the age of twelve I closed the palate cleft, and in his case articulation was so perfect that no variation from the normal could be detected. A lady, twenty-eight years of age, had cleft complete of the soft with partial cleft of

the hard palate. After operation she became a salaried member of a church choir, her voice being entirely free from nasal tone. In many the improvement is partial but progressive, especially in children where pains are taken to educate them properly. In some cases where I have been able to retain charge of the patient I have rendered assistance, as growth took place, by subsequent division of the palate muscles, thus increasing the movement of the velum.

In all cases, children and adults, the effect upon the *morale* has been good, and for this reason, if no other, the operation is justified.

SALICYLATES IN THE TREATMENT OF PLEURAL EFFUSIONS.

Dr. George Dock (*Therap. Gaz.*) reviews this subject, and draws the following conclusions:

1. Salicylic acid and its salts are among the most effectual agents in the treatment of pleurisy with effusion.

2. In effective doses the remedy is harmless, and with proper care in the selection of the preparation and its administration, causes little or no discomfort to the patient.

3. Salicylates act most promptly in pleurises with serous effusion of recent origin or of long standing, but they are efficient in simple dry pleurisy, and often act favorably in secondary pleurisy.

4. There is no evidence that they are useful in suppurative cases.

5. The drug acts as a diuretic, but may have an effect on the pathological process, or on the cause of the disease.

6. Salicylates have a more marked action on pleurisy than the diuretics commonly so-called.

7. The duration of treatment, with salicylate preparations, is less than with diuretics, common salt or roborant medication.

8. The remedy can be used at the earliest period, and favorably affects all symptoms.

9. The drug may be given in the form of the acid, or any of its salts, in doses of a drachm of the former, or one or two drachms of a salt daily. In ordinary cases it is not necessary to give the large doses; and sixty to ninety grains of sodium salicylate, or of salol, may be considered full-begining doses, to be diminished one-third or one-half, if the effect is manifest.

10. The ordinary precautions must be observed in giving the drugs, and during their administration the total amount of urine should be measured daily.

FOR THE REMOVAL OF WARTS.

For the removal of warts Dr. R. B. Morison, of this city, prescribes the following:

℞.—Hydrarg. bichlor. . gr. v.
Acid. salicyl. . . ʒ i.
Collodion. . . ʒ i.

He increases the bichloride or mercury to thirty grains in the same quantity of collodion, if the milder application does not answer. It is applied every day once, the upper crust of the previous application being removed before a fresh one is made. Four such appilcations generally soften the wart to such a degree that gentle traction removes it painlessly, the further dressing being any simple ointment.

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BALTIMORE, JANUARY 6, 1894.

Editorial.

THE NEED OF A NEW HALL FOR THE LIBRARY OF THE MEDICAL AND CHIRURGICAL FACULTY.

If a vote of the members of the Faculty was taken, we do not doubt that a large majority would pronounce the Hall, now occupied by the Library, as unsuited for the purposes of the Faculty. The Hall is inconveniently located and is so inaccessible that many are deterred not only from using the Library, but from attending the meetings of the Faculty and of the local societies which now meet in it. There has been a constant complaint upon the part of many members of the local societies of the poor attendance upon the society meetings, all of which grows out of the location of the Hall. This complaint has increased to such an extent that a protest has been made and a threat to leave the Hall has been expressed by more than one of the local societies. The time has come when the Faculty should consider these complaints and look out for a new location.

The Hall, whilst large and roomy, is cold and cheerless in winter, and damp and musty in spring, summer and fall. These latter disadvantages, in connection with its inaccessibility, outweigh every other advantage which it possesses.

In a city as large as Baltimore there are a number of buildings for rent far more suitable for a Library Hall than the one now used for that purpose and a change of location is not only necessary, but is demanded if the Faculty is to prosper.

This matter of location is too important to be left in its present position. Year after year the subject of a change has been agitated and yet the movement has taken no practical form. The Faculty drifts along in this easy way and falls very far short of the good work it could render the profession through the Library were the Library properly located and more energetically conducted. No individual or committee seems responsible for this condition of affairs. It is necessary that the Faculty as a body should act, and act promptly.

The question of purchase of a permanent location has been agitated time and again, but in this, as in other matters of vital importance to the Faculty, no practical results have followed. It is a reflection upon the profession of this city and State that enough interest has not developed to bring about a better condition of affairs, looking to a more perfect organization and development of profesional interests in this city.

A medical hall is not only needed, but is positively demanded. With such a building, the property of the profession or of the Faculty, a Medical Library will grow, a Nurses' Directory will prosper, the local societies will enjoy more energetic life and activity and the organization of the profession of the State will speedily follow.

Let this work begin now and let it grow until the profession can point with pride to its liberality and prosperity.

THE TOXÆMIA OF PREGNANCY.

That the pregnant woman should be more susceptible to the influence of toxæmia is readily understood when the dual existence, in her body, of waste material is considered. She must not only eliminate the waste products of her own organism, but the results of tissue changes which are contributed by the fœtus.

In a paper recently read before the Obstetric Section of the New York Academy of Medicine, Dr. E. P. Davis, of Philadelphia, pointed out the influences which contribute to toxæmia and the methods of treatment for the condition.

The kidney is the organ primarily involved, since it is through the agency of this organ the excretion of waste material is effected. Kidney failure is the first and prominent symptom calling attention to the toxæmic condition. The importance of repeated and careful examinations of the urine of the pregnant woman is the only method of estimating the presence of waste material and of anticipating toxæmia.

Dr. Davis regards it important to determine the amount of urine excreted and the percentage of urea. The value of microscopical examination, he claims, cannot be over-estimated. Marked diminution of urea is always found in cases having or being threatened with eclampsia or with symptoms of toxæmia. The occurrence of albumin he regards as significant, but in cases where microscopical examination fails to show pathological elements, the presence of albumin is not to be regarded as important.

The presence of glucose or lactose has no direct relation to the toxic condition.

The treatment of the toxæmia of pregnancy must be directed to excretion by five organs: kidney, liver, intestine, skin and lungs. The necessity for prompt termination of pregnancy must be kept in view. Milk he regards as the best food; pure water should be given, but not in excess. The liver plays an important function and should be stimulated with the occasional use of calomel and soda followed by a purgative which will produce frequent liquid stools. The potassium salts are contra-indicated. Colocynth is regarded as valuable. The skin should be kept in healthful action by hot baths and hot wet sheet.

Free and copious elimination of waste products is the end sought. When this general plan fails the prompt induction of labor offers the most reliable hope.

In the discussion which followed Dr. Davis' paper, the question of accouchement forcé was advocated by the majority of the speakers, when eclampsia was actual or threatened, as the best and quickest means of saving the mother. In the writer's experience, this has been the most successful and reliable of all methods of dealing with eclampsia. We believe it will be the method of the future.

Reviews, Books and Pamphlets

A Practical Treatise on Diseases of the Skin. For the use of Students and Practitioners. By J. Nevins Hyde, A. M., M. D., Professor of Dermatology and Venereal Diseases in Rush Medical College, Chicago. New (3d) edition. In one octavo volume of 802 pages, with 9 plates, of which 3 are colored, and 108 engravings. Cloth, $5; leather, $6. Philadelphia: Lea Bros. & Co., 1893.

The third edition of Dr. Hyde's book has been made necessary by the demand, which has exhausted previous editions. The work has taken a front rank as a text-book and work of reference. The present edition has been thoroughly revised and enlarged to the extent of one hundred pages. A number of new pages and colored plates have been added.

Annual of the Universal Medical Sciences. Edited by Charles E. Sajous, M. D., and seventy associate editors. The F. A. Davis, Company: Philadelphia, New York, Chicago and London, 1893.

This work now appears in its sixth annual series in the form so familiar to the profession. It seems unnecessary for us to refer to its character and usefulness. It has made its annual visits with such frequency and regularity that its value is now fully recognized. The present series embraces the work of the past year and covers the ground so thoroughly that as a reference of medical advance in every department nothing seems wanting. We commend the work to physicians generally.

Medical Progress.

MEDICAL LEGISLATION.

Medical legislation in the United States this year has had its usual history: many good bills have failed to pass, and, as in compensation, some very bad ones have also been defeated.

With a view of keeping Canadian pleuro-pneumonia out of the United States, the Secretary of the Treasury instructed collectors of customs on the northern frontier that meat cattle may enter the United States from Canada only at Buffalo, N. Y., after passing the inspection prescribed by the Secretary of Agriculture.

In Massachusetts the law providing for the registration of deaths by physicians, in connection with the obtaining of a burial permit by undertakers, has been amended so that in cases of still-born children and those dying immediately after delivery, the same form is required as in other deaths, and a penalty is provided for making false statements. A law was passed providing that "sweat shops" shall be licensed and superintended by the police, and that in cases of danger from infectious diseases or vermin, the State Board of Health shall take charge and control. A bill was passed requiring local boards of health to notify the State Board of the existence in their districts of any disease dangerous to the public health. Hereafter plumbers must be licensed, and must pass an examination. The examining boards consist of the chairman of the local board of health and the inspector of buildings. It will be no longer possible for any ignoramus to practise plumbing, but the practice of medicine is still unrestricted.

The Michigan State Board of Health

unanimously decided that consumption is a dangerous, communicable disease, and must be reported by physicians and householders to the several health boards.

In New York a bill was passed providing for the levying of a special annual tax for the support of the insane. The tax of one-third of a mill, imposed by the bill, is expected to yield about $1,350,000 each year. The New York City Board of Health took similar action in regard to tuberculosis to that of the Michigan State Board.

The legislature of Ohio passed a law regulating the practice of veterinary surgery, and requiring an examination before allowing any one to practise upon horses. Ohio has no medical practice law.

In Pennsylvania the legislature passed a bill establishing a medical council and three State boards of medical examiners, corresponding to the three so-called schools. The boards are to be appointed by the Governor, and their work is to be supervised by the medical council, consisting of the Lieutenant-Governor, the Secretary of Interior Affairs, the Superintendent of the State Board of Health, with the presidents of the boards. Applicants will be required to have studied medicine for four years.

In Tennessee an act was passed to prevent the spread of communicable diseases, providing that the local health authorities shall be notified of all cases or suspected cases of communicable disease, except any venereal disease. The local board is required to notify both the State Board of Health and the Board of Education of the district in which the case occurs.

In Washington the State legislature passed an anti-cigarette law, making it a criminal offence to manufacture, buy, sell or give away, or to have in one's possession, cigarettes or cigarette-paper.

The Superior Court of New York City has ruled that when a married woman is so injured through the negligence of another person as to miscarry, her husband can recover damages for the loss of the child.

The Supreme Court of North Dakota has ruled that mental suffering is as properly considered in estimating damages as is physical pain. The impairment of mental powers, naturally a proper element when proved, is only to be considered by the jury when claimed in the suit and evidence.

The Supreme Court of Illinois has made the following ruling regarding expert medical testimony: "A practising physician who is shown to be a graduate of a regular college and to have practised his profession for many years, is competent to give his opinion upon a hopothetical question, setting forth the symptoms of a deceased person, whether the death was from the effects of arsenical poisoning, although he may not be shown to have had any case of such poisoning. A medical witness, in giving his opinion as an expert, is not confined to opinions derived from his own observation and experience, but may give an opinion based upon information derived from medical books."

The Supreme Court of Wisconsin has ruled that when a married woman sustains a personal injury, and her physician does not caution her to avoid pregnancy, and there is no evidence that her injury was such that he should have

done so, her pregnancy occurring after the accident, even if it prolong her injury or delay her recovery, is not necessarily, and as a matter of law, sufficient to justify a reduction of damages.

The Legislative Assembly of the Island of Jersey declared by vote that quarantine is not preventive of cholera, and therefore refused to establish a quarantine against vessels from ports alleged to be cholera infected.—*Boston Med. and Surg. Jour.*

A PLEA FOR THE SLOW AND GRADUAL EXHIBTION OF ANÆSTHETICS UNTIL THE "FIRST STAGE," OR STAGE OF EXCITEMENT, HAS BEEN PASSED.

Dr. John B. Richardson, of Louisville, Kentucky, says in *Med. Rec.:*

In your esteemed *New York Medical Record* of October 28, 1893, pp. 573 and 574, there appeared an article by Dr. A. M. Adsit, of Hastings, Mich., which well deserves to be written in enduring letters of gold upon the minds and memories of all physicians and surgeons—and this method of administration should be emphasized by all teachers in our colleges—concerning the only proper and humane manner of administering anæsthetics.

For any one to speak of that "whereof he knows" he must have had personal experience, not in anæsthetizing others only, but having had another place him under the influence of an anæsthetic.

From my reading, experience (of thirty years), and interchange of opinion touching this subject, I am positive that a very large majority of my professional brethen deem it essential—more especially in the administration of ether as an anæsthetic—for the immediate and remote safety of his subject, that he must produce anæsthesia as rapidly as possible. This is almost tantamount to asphyxiation.

Dr. Adsit very truly says: "To avoid these bad effects (the initial disturbance of inspiration, preventing the proper aëration of the blood, and, as a result, we have the flushed face, the distended veins, the coughing, the jerky, catching respiration, and I add that horrible dyspnœa, and its concomitant sensation, that you are powerless to exhale the irritating ether vapors already inhaled, and the feeling that your heart will burst from over-distention, the increased flow of mucus, and the wild struggle for liberty), two rules must be observed: 1st, begin the administration with air lightly charged with ether; 2d, always permit all the air necessary to sustain life comfortably." Physicians seem to forget that neither chloroform, ether, nor any other anæsthetic can be substituted for air. "There is no good reason why a patient does not require as much air while taking an anæsthetic as at any other time. If you think that they secure the needed supply of air, place a cone over your own face and permit some one to hold it down tightly for five minutes."

Now this is not overdrawn, for I would much prefer the cone being pressed down tightly upon my face for five minutes, and take my chances for the small amount of atmospherical air, than to have that modicum surcharged with vapor of ether or chloroform.

All of us probably have been able to anæsthetize children while asleep, but to enable us to do so, we had to dilute the anæsthetic with air freely at first, and

administer it slowly, gradually increasing its strength, that no disturbance of the patient should occur.

If in thus seconding the mode of slow and gradual exhibition of anæsthetics —which my personal experience enables me to do—I shall influence some of my brethren to substitute this method for the rapid and sudden manner generally employed, and shall thereby save some poor mortals this greater suffering and shock than at times the operation performed proves to be, I shall not have pleaded in vain.

THE PUBLICATION OF PHYSICIANS' PORTRAITS.

The Maltine Manufacturing Company writes to the *New York Medical Journal* as follows: your reference to our calender for 1894 demands our attention. While you did not mention us by name, the reference is so direct that the physicians who received the calender can not but know to whom you referred.

It has been our custom for several years to send to the medical profession throughout the United States portraits of eminent physicians and surgeons, and, inasmuch as their distribution has been scrupulously confined to medical men of good repute, no objection has been offered by those gentlemen whose likenesses we reproduced. Not a copy of this calendar, or any of our numerous publications, has ever been sent to the laity.

Maltine is distinctly not a "patent medicine," nor has it ever been advertised to the public, and therefore we have considered it within our province to distribute portraits just as we have promulgated testimonals from the most eminent physicians and chemists in this country and Europe.

We have statistics to prove that ninety per cent. of the physicians of the United States prescribe Maltine. This fact, in addition to the fact that we reach the patient *only through the physician,* would seem to amply vindicate our use of the likeness of a physician whose pictures are on public sale and have continually appeared in the public press, and who is well known as a public man.

The portraits referred to were not used to push the sale of our preparations, as was the portrait of Dr. D. Hayes Agnew, recently published by us. It will be remembered that we printed under Dr. Agnew's portrait a facsimile of his indorsement of Maltine. Our only reason for publishing the portrait of Dr.— was because we thought it would interest his medical brethen, who have shown so high an appreciation of the series of likenesses we have already published.

We should like further to say that as soon as objection was made by him we suspended the distribution of the calendars, as we would not knowingly offend even one of the honorable profession to whom we are so greatly indebted.

MASSAGE IN DISEASES OF THE SKIN.

In a paper read before the Section for Dermatology of the British Medical Association (*British Journal of Dermatology,* September, 1893), Eccles considers the effects of massage in cutaneous diseases. The effects of massage upon the skin vary with the character of the manipulation. Light friction produces relaxation of the vessels and warm redness,

With firm rubbing, loose epithelium is removed, the contents of the sebaceous follicles is expelled, dilatation of arterioles, insensible perspiration, and sometimes sensible sweating ensue; lymph vessels are unloaded, and venous circulation is greatly stimulated. Rolling and squeezing produce increased vascularity of the part, and absorption by blood and lymph vessels is accelerated.

Light friction reduces surface temperature; firm friction, kneading and rolling increase it. Upon the cutaneous nerves light friction produces no perceptible effect. Firm friction increases tactile sensibility, and improves local sense. Kneading immediately decreases both; it also reduces temperature sense for heat, less so for cold.

It is in lesions characterized by the accumulation of inflammatory products in overloaded lymph spaces, clogged lymphatic channels and blocked glands, that massage proves most certainly valuable.

In scleroderma and psoriasis mechanotherapy has been useful, while in examples of various forms of vaso-motor enfeeblement and cutaneous neuroses, *e.g.*, pruritus, anidrosis, and alopecia, the effects of treatment were more or less marked. In acne and comedones dry massage was most efficacious.—*Union Med. Mag.*

ELEVENTH INTERNATIONAL MEDICAL CONGRESS.

Dr. A. Jacobi, of New York, Chairman of the American National Committee of the Eleventh International Medical Congress, announces:

1. Papers to be read in any of the Sections of the Congress should be announced on or before January 31, 1894, to the Secretary-General, Prof. E. Maragliano, Ospedale Pammatone, Genoa, Italy.

2. The title of the paper ought to be accompanied with a brief abstract of its contents and conclusions.

3. The program to be distributed will contain the titles of all papers announced before August 31, 1893, and since.

4. The reductions granted by the railway companies months ago will be available from March 1 to April 30, 1894.

"Travelling documents" will be sent to the address of every subscriber on or before February 15, 1894, and after that date congressists will have to apply to Dr. Jacobi.

Members' dues are five dollars (money order to Prof. L. Pagliani, Rome); guests' (wives and adult relations) two dollars; medical students no fees. All are entitled to travelling documents.

FOOTBALL MORTALITIES.

Already five deaths have been reported this fall from accidents while playing football, one each from New Jersey, Indiana, Ohio, Wisconsin, and Connecticut. The two last were caused by fracture or dislocation of a cervical vertebra and crushing of the spinal cord. One of them occurred near Farmington, Conn. The second took place during a game between the Toledo (O.) High School and the Adrian (Mich.) College, which was played at Adrian recently. A Toledo player, Carew, says the report, "had the ball, and downed to save it. Three Toledo boys dropped to save him, and in an instant the Adrian team was upon them. When the struggle was over, Carew remained motionless upon

the ground. The crowed cried, 'Fake!' but it was soon discovered that the young man's neck was dislocated." Upon examination it was found that his body was paralyzed from the chest down, and his spinal column injured, and he died the next morning without having recovered conciousness. Another member of the Toledo team was kicked in the groin, and injured so badly that he could not return to his home. A third player suffered serious injury to his right leg. English newspapers just received mention the death of a football player in West Hartlepool, "from the effect of injuries received in a football match, when he was kicked severely in the stomach."

English medical journals every year report a long list of deaths and casualties from football; but up to this year no fatal accident, so far as we know, has been reported in the United States. A mortality of five with the football season not over, however, is most startling. The general results of football playing have been heretofore considered so good as to outweigh some of the disadvantages. But the question now arises whether half a dozen deaths and hundreds of serious accidents are not too great a penalty to pay for this sport.

The football games that occur in the city of New York have degenerated into great professional shows which are made the excuse for unlimited betting, and which end in vulgar carousals. It is quite time for college authorities to interfere.—*Med. Record.*

PURULENT OPHTHALMIA.

Hindl (*Ophthalmic Record*, August, 1893), in an abstract of a paper upon purulent ophthalmia, from the standpoint of its specific microbic cause, gives, among others, the following conclusions:

1. That all cases of purulent conjunctivitis are of microbic origin, and due to Neisser's gonococcus.

2. That all cases originate from a gonorrhœal focus, by devious paths often, and not always traceable.

3. That those parts of the conjunctival sac having a cylindrical, or a modified cylindrical epithelium, namely, the palpebral portions and that of the fornices, are the seats of election of the micro-organism.

4. That the location of the gonococcus, on the mucous membrane, is first super-epithelial, then inter-epithelial, and still later sub-epithelial, and all combined.

5. That its special habitat is within the pus cell, yet it is also extra-cellular as well as intra-epithelial.

6. That the associated inflammation of the adjacent lid-tissues is due to the lymphatic absorption of the ptomaines of the microbe.

7. That the compact stratified epithelial layer of the scleral conjunctiva and cornea is very resistant to the attack of the gonococcus.

8. That ocular complications are due to pressure-necrosis, producing an infection atrium through which the streptococcus, and may be the staphylococcus, find ready entrance to tissues with greatly impaired physiological resistance and often rapidly destroy them; resulting in perforation of the cornea, intra-ocular infection and loss of the eye. This is a secondary infection.

9. That the therapeutical indication is the mechanical removal or destruction

of the gonococcus with its ptomaine, and that if this is done early and thoroughly in the weeping stage, the period of acute inflammation will be cut short and the ocular complications avoided.

10. That it is well, in the incubative stage, even without positive evidence of a gonorrhœal origin, to regard with suspicion all cases of severe monocular catarrh, and especially so in the female, irrespective of age or condition, and to treat them as if due to the gonococcus.

11. That, of all local remedies, nitrate of silver is the most potent and at the same time least irritating microbicide we possess. It prevents complications and can be used in sufficient strength to destroy the gonococci without risk of injury to intact ocular tissues and that solutions of greater strength than two per cent. are unnecessary.—*Boston Medical and Surgical Journal.*

Medical Items.

Dr. Wm. Hunt, Senior Surgeon to the Pennsylvania Hospital, has resigned, having served 30 years on the surgical staff.

The report of the Health Department of New York City shows that there were 6,000 deaths in that city during the past year from consumption.

The Homœopathic Examining Board of New York State, it is stated, has rejected fifty per cent. of the applicants who have appeared before it.

August Martin, heretofore docent, has been made Professor of Gynæcology and Obstetrics in the University of Berlin.

The Richmond City Hospital has been purchased by the College of Physicians and Surgeons of that city for $18,489.39.—*New York Medical Record.*

The Physician's Magazine, a monthy chronicle of the advances of the medical sciences, edited by Robert C. Kenner, A. M., M. D., Louisville, Ky., has just been issued.

To remove the smell of tobacco from the mouth or breath, Grahame advises bromo-chloral, a few drops in a glass of water, with which the mouth is to be well rinsed.—*Medical Age.*

Dr. Arthur W. Edis, of London, well-known in this country as an author and specialist in the departments of obstetrics and gynæcology, died on November 16th, at the age of 53 years.

The Medical Department of the Cincinnati University Degrees are said to be on sale and selling high in London, whereas none have ever been issued by that institution.—*N. Y. Medical Record.*

Mathews' Medical Quarterly, devoted to diseases of the rectum and gastro-intestinal diseases, rectal and gastro-intestinal surgery, J.M. Mathews, M.D., editor, Henry E. Tuley, M. D., assistant editor and manager, Louisville, Ky., will be issued during this month.

Dr. Mary A. Suganuma, an American woman who is married to a Japa-

nese gentleman, has been licensed by the government to practise medicine in Nagasaki. She is the first woman physician ever licensed for that purpose in Japan.

The British Medical Association will hold its next annual meeting at Bristol on July 31, August 1, 2 and 3, 1894, under the presidency of E. Long Fox, F. R. C. P. An Address in Medicine will be delivered by Dr. T. Grainger Stewart, of Edinburgh; an Address in Surgery by Mr. J. Creig Smith, of Clifton; and an Address in Public Medicine by Sir Charles Cameron, of Dublin.

The Czar has recently been adjusting medical fees in Russia. The population is divided into three classes according to vocation, and payment of fees is exacted under severe penalties. The first class are asked to pay two dollars and seventy-five cents for each consultation; the second class one dollar and sixty-five cents; while the third class, which, by the way, comprises the masses, is limited to nineteen cents. If the fee were proportioned to incomes, it is said the first class would pay twenty-seven dollars; the second, sixteen dollars; while the fee for the third class would remain at nineteen cents.

The Irish victims of the cholera plague of 1847, who died in hospital at Kingston, Ontario, will be commemorated by a statue to be erected on a mound in the hospital grounds, under which the remains of many of the deceased are interred. Over one thousand Irish immigrants succumbed to the dire disease at Kingston, and Archbishop Cleary, of that city, proposes that their memory be honored by the erection of a life-size picture of an angel chiseled from Carrara marble. It will be made from a solid block three tons in weight, and will cost one thousand two hundred dollars.

In the patent office at Washington is a disease-proof suit of clothes, intended to be worn by an operating surgeon. It is a complete suit of rubber armor, somewhat resembling a diver's dress. Being air-tight, no germs can enter it. Beneath each foot is a small bellows, which being compressed by the action of walking, blows fresh air through the armor. The air enters and is filtered through a germ-proof diaphragm under the foot, passing upward and out through a similar diaphragm at the top of the head. The physician is enabled to see by two glass eye-pieces.— *New York Medical Record.*

A number of experiments have been made in London to test whether bullets carry infection. The bullets infected with the micro-organisms were fired into tin boxes containing sterile gelatine peptone, and in every case the infected bullets planted growths of these organisms in the gelatine. Moreover, clean bullets fired through flannel infected with the bacilli also produced corresponding growths in the gelatine, an experiment showing the danger of infected clothing in war. On the other hand, clean bullets simply fired into the gelatine produced no organisms in it except the ordinary moulds and bacteria of the atmosphere. It was proved that the heat of a fired bullet was not sufficient to destroy any bacteria on it or in the clothing through which it passed.

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REPORT OF TWO CASES OF EMPYEMA.

BY RANDOLPH WINSLOW, M. D.,

Professor of Anatomy and Clinical Surgery, University of Maryland.

A collection of pus in the pleural cavity may be due to a variety of causes. It may develop spontaneously or as a sequence to pleurisy or pneumonia, or it may follow some traumatism, such as a penetrating wound of the chest. Whatever the cause of the affection may be, the principles governing its treatment are the same. In children a cure may result from the removal of the fluid by aspiration, but this is very uncertain. In adults a cure is not to be expected from this method of treatment, and nothing short of complete evacuation of the pleural cavity, with drainage, is to be relied on as a therapeutic procedure. When the pleural cavity has been filled a long time with pus, the lung becomes compressed, and is more or less bound down by bands of lymph. Very frequently, when the pus is removed, the lung is unable to expand and fill the pleural cavity. At the same time, the natural convexity of the ribs prevents a sinking in of the parietes, and as a consequence of these two facts, a cavity of more or less size remains between the chest walls and the compressed lungs. In these cases, simple drainage is not sufficient, and it is necessary to excise a portion of several ribs, in order to allow the chest walls to collapse, and come in contact with the lung. This procedure is known as Estlander's operation. I happen to have two cases of empyema in my

wards at the University Hospital at this time that have been subjected to operation, with a successful result, which I desire to bring before the society for its examination and criticism. The histories of these cases are as follows:

CASE 1.—Josephine Davis, white, age 42 years, dressmaker, married, was admitted to University Hospital on Oct. 9th, 1893. About one year ago she was a patient in the hospital, sick with pleurisy and pneumonia, from which she apparently recovered. At the time of admission she presented a very emaciated, cachectic appearance, was coughing and expectorating pus. Just above the right breast was a red inflammatory swelling, looking like a growth of the breast itself. This fluctuated and evidently contained pus. Both in front and behind, the chest was flat on percussion, and the vesicular murmur was absent, though quite distinct; bronchial breathing was present near the spinal column. She had pain and oppressed breathing Empyema was diagnosticated, and the patient prepared for operation. The urine contained no albumen or sugar, was slightly acid in reaction; specific gravity, 1025. On Oct. 14th, an incision was made into the mammary swelling and a huge stream of pus poured out. The patient was then turned on the left side and an incision made posteriorly about the eighth rib and in a line with the inferior angle of the scapula. A small piece of a rib was excised, in order to allow free drainage, and two tubes were introduced through the posterior opening. Pus escaped freely through both incisions, estimated to be ½ gallon in quantity, and not at all offensive. The patient became very weak during the operation, but rallied promptly. No irrigation of the cavity was done. The temperature never exceeded 99° after the operation. In a few days she was sitting up, the tubes came out and in two weeks the wounds were healed and the patient was well. She has been doing domestic work at the hospital ever since.

If the history given by this woman is correct, the result is very remarkable. According to her account, she has been ailing ever since she left the hospital, 12 or 13 months previous to her return. It is incredible to me that her pleural cavity could have contained pus for that length of time, until it was practically filled, without the lung becoming permanently bound down and compressed. In two weeks from the time of operation, she was well, with the lung fully expanded.

The next case was of greater severity, in that a cavity had been left, after an operation, done in New York, six months previously. In this case, a considerable portion of two ribs was removed, in order to allow the chest walls to collapse, and come in contact with the lung. The result has been almost as striking as in the first case.

In both cases I made the incision, posteriorly, in such a position that free drainage would be permitted when the patient was in a recumbent posture, and this is the object I have usually had in view in similar cases. I do not irrigate the pleural cavity at once, if at all, as I have seen harm result from the entrance of water into the bronchial tubes.

CASE II.—August Linstrum, 30 years old, a native of Finland. His occupation recently was that of an oysterman. He was admitted to University Hos-

pital on Oct. 31st, 1893. At this time he was very sick; temperature 101, pulse 104, respiration 24. A very peculiar and unpleasant odor emanated from his body, which was found to be due to a discharge of pus from an opening in the left side of the thorax. As the man spoke scarcely any English, his history could not be ascertained, but there was an opening upon the anterior part of the left side of the chest, which he said had been made by a surgeon in New York. What operation was done is conjectural, though probably only an incision for drainage. From this opening offensive pus escaped. The physical signs of an empyemic cavity were present; flatness on percussion, and loss of respiratory sounds over a considerable area. He was also expectorating pus of the same character as that which flowed from the chest. The man was thin and anæmic. He had been down the bay on an oyster boat, and the hard work and exposure had made him much worse.

His urine was 1016 specific gravity, and did not contain albumen or sugar. On Nov. 3rd an incision was made posteriorly about the ninth rib, and a considerable portion of two ribs excised. A free discharge of stinking pus took place from this opening. The pleural cavity was not irrigated, as it was feared that water might get into the bronchial tubes. Subsequently, after the communication with the tubes had had time to close, the cavity was flushed out with hot water, with very satisfactory results. Two drainage tubes were introduced, which allowed free escape of discharge. The pus soon diminished in quantity, and became free from unpleasant odor the drains were gradually shortened, and on Nov. 24, three weeks after the operation, were removed, permanently. On Dec. 3rd, it is recorded that the "patient is about the ward and working." He has gained enormously in flesh and strength, and has ceased to cough or expectorate. There is no discharge from his chest, the wounds have healed, and he appears to be cured. There is still marked percussion dulness posteriorly, and a weak respiratory murmur, and a decided sinking in of the affected side.

REMARKS UPON THE TREATMENT OF STRICTURE OF THE SIGMOID FLEXURE AND OF THE FIRST PORTION OF THE RECTUM.*

BY JOHN B. DEAVER, M. D.,

Professor of Surgery in the Philadelphia Polyclinic and Assistant Professor of Surgical Anatomy, University of Pennsylvania.

Mr. President and Fellows: My object in offering a few remarks upon stricture of the sigmoid flexure and of the first portion of the rectum this evening is to obtain the views of the Fellows present upon this, which is certainly a very important, subject, and to place upon record a case of stricture of the terminal portion of the sigmoid flexure and of the first portion of the rectum, recently under my care, in which the passage of a flexible rubber bougie (Wales) but one size, French scale, larger than that which had been passed many times before, caused perforation of the rectum below the stricture, resulting in the death of the patient within twenty-four hours thereafter from peritonitis.

*Read before the Philadelphia Academy of Surgery, Dec. 4, 1893.

In order to discuss this subject to the best advantage I may be permitted to refer to one or two points in the anatomy of the first portion of the rectum; also to say a word or two concerning the diagnosis of stricture situated beyond the reach of the finger.

The rectum does not, as is usually described, begin at the brim of the pelvis opposite the sacro-iliac synchondrosis, whence it extends to about the centre of the third piece of the sacrum and descends in front of the sacrum, the coccyx, etc.; but commences at the terminal part of the omega loop, to which attention has been called by Treves as being the shape of the sigmoid flexure, and not "S" shaped in answer to the description in the text-books on anatomy. Careful examination by myself of many bodies has confirmed the above statement. All of the omega loop, which includes the first portion of the rectum, occupies the pelvis in the adult. It will thus be understood that the first portion of the rectum makes with the second portion a decided angle; therefore, an instrument of the calibre of the normal bowel, unless it be a flexible one which will pass through the third and the second portions, will not prove anything regarding the calibre of the first portion. Again, from the relation borne between the second and the first portions of the rectum much may be learned about the latter if it be infiltrated, upon introducing the finger into the second portion, through the walls of which the infiltration may be detected. The best form of flexible rubber bougie is one which is hollow, as is the Wales instrument, to the lower end of which can be attached a fountain or Davidson syringe, and water thrown through this, favoring its passage by drawing out of the way the folds of the mucous membrane which would otherwise form an obstruction to its introduction.

The diagnosis of stricture of the second and third portions of the rectum is readily made by the sense of touch. When the index finger is not long enough to reach beyond the second portion with the patient lying on the back, it may be done with ease if the patient be turned upon the left side and the thighs slightly flexed upon the abdomen and the finger introduced into the anus from behind, as the tissues of the perineum can be carried a little distance in advance of the web of the index and middle finger. Contraction in this part of the bowel can often be diagnosed by the introduction of a short, flexible Wales bougie, but the finger is the more trustworthy instrument. This, too, is the only portion of the bowel where we will all admit that the operation of proctotomy for the relief of a constriction is admissible. The soft, flexible rubber bougie is the only instrument that can be safely as well as surely carried through the upper portion of the rectum and the sigmoid flexure. The use of the non-flexible rectal bougie is not only an unsafe instrument, particularly where the stricture is situated beyond the second portion of the rectum, but one which may mislead the surgeon in making a diagnosis of stricture when it does not exist.

The first portion of the rectum, like the sigmoid flexure, is connected to the back part of the abdominal cavity by a reflection of the peritoneum, the meso-rectum. On account of the bend made by the junction of the first and second

portions of the rectum it can be readily seen how the point of a non-flexible bougie is arrested by contact with the wall of the bowel at this point, which offers resistance to its further passage, and a diagnosis of a pathological obstruction made; or it may be that the bowel, owing to the meso-rectum which, if preternaturally long, will be carried in advance of the point of the instrument to or beyond the median line in the neighborhood of the pubis, while if the instrument by chance should pass into the sigmoid flexure, the latter, owing to the meso-sigmoid, may be carried to or beyond the median line in the neighborhood of the umbilicus, which, in either event, might give rise to the belief that the bougie had passed into the bowel beyond, if not through, a supposed stricture.

There is a question of doubt in the minds of some as to the possibility of being able to carry a flexible rubber tube or bougie through and beyond the sigmoid flexure. This has been tried upon the dead body in a number of instances, and, not having proven successful, the deduction has therefore been made that it is impossible to do it in the living subject. While I am aware of the difficulty attendant upon the introduction of an instrument into the descending colon in the dead body, due chiefly to the absence of muscular contractility which faciliates the passage of the instrument, on the one hand, and offers a very decided barrier against its introduction, on the other, also to the absence of the normal moisture in the shape of the mucus, I cannot admit this to be so.

We well know that it is much easier to introduce a bougie through the normal urethra in the living subject than it is in the cadaver, and yet this ought to be more readily accomplished in the case of the urethra, where counter-pressure can be brought to bear to aid in the introduction of the instrument, than in the case of the bowel. I have very satisfactorily demonstrated upon many occasions the possibility of being able to circuit the sigmoid flexure with a soft, flexible tube such as the long flexible rectal bougie and the long flexible colon tube. In certain cases of intestinal obstruction I regard the passage of a soft, flexible tube into the sigmoid flexure, through which water can be thrown and the capacity of the large bowel ascertained, an important aid in the diagnosis between obstruction of the small and obstruction of the large intestine.

With the subjective symptoms of stricture of the large bowel present, namely, constipation, or may be attacks of diarrhœa, the passage of ribbon-shaped stools or of choppy stools covered with mucus and blood, or preceded or followed by the passage of mucus and blood attended by tenesmus, the lower portion of the rectum being intact, as proven by a digital examination, it does not absolutely follow that a stricture is the cause in all instances, as we may see this train of symptoms consequent upon a sub-acute or chronic catarrhal inflammation of the colon, of the sigmoid alone, or in ulceration of the sigmoid flexure; therefore, before we get more definitely at the exact condition of affairs it will be necessary to resort to instrumental interference in the introduction of graduated sizes of flexible rubber bougies, when a diagnosis can generally be arrived at with a very fair degree of certainty. This should

be done with all due care, and preferably by one experienced in the use of these instruments, as it has been demonstrated, particularly in the case I report to-night, that serious results can accrue from even the passage of a soft instrument, which argues strongly against the use of non- or semi-flexible instruments. From the relation the first portion of the rectum holds to the second when the former is the seat of extensive thickening or the walls contain a growth, upon digital examination this can usually be detected. In this class of cases, as in disease of the second and third portions, if in the female, much can be learned by careful digital examination of the vagina. I have on several occasions been able to feel with the finger masses in the first portion of the rectum, as well as the presence of a growth which had assumed some size in the terminal portion of the sigmoid by carrying the vault of the vagina well in advance of the examining finger, aided, too, by counter-pressure made over the abdominal walls. Further, I believe these examinations are better made without ether, having the feelings of the patient to guide us and with less risk of injuring the bowel.

Where a mass is suspected in connection with symptoms of stricture, which would suggest malignant disease, there is considerable to be gained, however, by giving the patient ether, under the influence of which the abdomen can be palpated more satisfactorily. Another means of diagnosis, that of dilating the sphincter of the anus and the introduction of the hand into the rectum and the sigmoid, I have never had the courage to do. In cases of great doubt, rather than resort to the last procedure, I deem it more advisable to do an exploratory abdominal section. Exploratory abdominal section, however, done for the purpose of diagnosis in the questionable cases of stricture of the sigmoid and the first portion of the rectum, I am not a strong advocate of, as I think that a diagnosis in the majority of cases should be made without resorting to so complicated a measure. While I am aware of the little risk attending an exploratory abdominal section under strict cleanliness, I think the principal objection to be urged against it is that it lessens the responsibility of the surgeon as a diagnostician. Apart from this, I fear the modern tendency is too much in the direction of exploratory incisions in other regions of the body, as well as the abdominal cavity, for diagnostic purposes.

The operation should be the natural sequence of the diagnosis and not the diagnosis to the operation. Perfecting one's self in diagnostic attainments is certainly more creditable to a surgeon than to feel forced to have to open the belly cavity to determine that which may be done without.

The majority of cases of benign stricture involving the first portion of the rectum are amenable to treatment by either the bougie or colotomy. Stricture of the sigmoid flexure, very rare except when of malignant origin, is not nearly so favorable for gradual dilatation by the bougie. Stricture here located, be it benign or malignant, if the inflammatory process has not advanced too far to permit of resection and anastomosis, or perhaps circular enterorrhaphy, the most that can be hoped for in the majority of

instances is the establishment of an artificial anus in the loin.

The choice between iliac and lumbar colotomy must depend upon the merits of each case; ordinarily I prefer to make the operation through the loin. The only advantage I can see in the anterior (iliac) operation is the opportunity it affords to determine definitely the condition of the bowel, if a resection and anastomosis or enterorrhaphy is possible, and, if nothing short of an artificial anus will suffice, the making of it at once.

In a paper I read before the Philadelphia County Medical Society two years ago upon "Lumbar versus Iliac Colotomy," I took the ground that the lumbar operation was the more preferable, inasmuch as the diagnosis of the condition rendering the operation of colotomy necessary should, in the majority of the cases, be made without having to open the peritoneal cavity as is done in the iliac operation.

In benign stricture of the sigmoid flexure and of the first portion of the rectum, I recommend gradual dilatation by means of the flexible rubber bougie. When this is not possible, more radical measures must be adopted. In malignant stricture of the above portions of the bowel the bougie can do nothing other than harm; directly, by hastening the diseased process, and, indirectly, by misleading the patient in having him believe that an operation will not be required. I believe the earlier radical operative interference in malignant disease of the bowel is instituted the better, and that if this practice was followed in all instances patient's lives would certainly be very materially prolonged and, in some cases, the disease perhaps be eradicated by removing it while yet local. What holds good in the uterus and elsewhere regarding affections of this character holds equally good in case of the bowel; the difficulty in affections of the latter organ being that, not exposed to the sense of sight, the diagnosis cannot be made with the same degree of certainty as in like conditions of the uterus, the breast, etc.

The advisability of furnishing the patient with a bougie and instructing him to pass it himself I am inclined to question; I think this is better done by the surgeon. In addition to instrumental and operative treatment, much is to be gained by constitutional treatment, particularly if the case be of specific origin; but unless the history clearly points to this we should be careful not to push the treatment too far for fear of the debilitating effects; by attention to the general health, by the administration of tonics, by advising the proper diet, by giving tonic laxatives to have the bowels moved daily.

In cases where tenesmus is excited by the presence of a collection of mucus it is advisable to use a long flexible rubber tube beyond the stricture, through which the bowel can be irrigated with warm water or with mild antiseptic astringents.

The following is the case I have referred to above: F. W. R., aged about thirty, consulted me July 27th, stating that he had a stricture of the large bowel, for which he was passing at intervals of from four to five days Nos. 9 and 11 Wales bougies, by the advice of his physician. Upon being questioned, he described the symptoms characteristic of stricture of the sigmoid flexure or

of the latter and first portion of the rectum. He further stated that without the aid of medicine taken internally or the use of enemas it was impossible for him to have a passage. Digital examination of the rectum revealed nothing other than a rather capacious organ. Examination with the bougie showed the presence of an unquestionable obstruction nine inches within the anus. I advised continuing local treatment, but disapproved of his using the bougie himself. I passed a bougie up to the time of his last visit to me, when, upon introducing one a size larger than the one usually used, namely, No. 12—which I had also passed before with but little difficulty—as the point of the instrument was engaging in the stricture he suddenly lurched forward upon the operating chair, and before I could withdraw the instrument he rebounded, as it were, upon the point of the bougie. This was immediately followed by severe abdominal pain. I feared the bowel had been penetrated on the anal side of the stricture, but was not certain, as the instrument was withdrawn clear of blood; neither was there any blood passed after its withdrawal. I advised that he go to the hospital, where he would have the benefit of absolute rest and at the same time give me the opportunity of having him closely observed. Contrary to advice he went to his place of business, but came back to my office some time afterward, complaining of the pain being as severe as when he left me earlier in the morning. He now consented to go to the hospital. The pain was so severe as to require large doses of morphine to relieve him. He would not consent to an abdominal section, therefore I was powerless to do other than administer anodynes, counter-irritants, etc. He died the following night. The abdominal walls remained perfectly rigid, with the absence of tympany until four hours before he died, when there was pronounced distention. An autopsy made shortly after death showed the presence of a purulent peritonitis and a linear stricture involving the terminal portion of the sigmoid flexure and the first portion of the rectum. The bowel immediately below the stricture, which was very much dilated, with the wall nearly as thin as tissue paper, showed a perforation. Upon opening the bowel there were present cicatrices which were evidently the result of ulceration. There were present old adhesions in the abdominal cavity in the neighborhood of the descending colon and sigmoid flexure. Upon opening the chest there were present adhesions at the apices of the lungs. No further evidence of organic disease.

A few hours before his death, in a conversation with his mother, I learned, much to my surprise, that he had for some time back been giving himself an enema after each meal; this, to some extent at least, evidently accounted for the very much dilated and thin condition of the wall of the bowel, rendering it susceptible to penetration by the bougie.

The Philadelphia Polyclinic has arranged to give a week upon the diseases of the heart and lungs, commencing on January 22nd, the instruction being arranged on a plan similar to that pursued in the recent week devoted to cataract.

Society Reports.

GYNÆCOLOGICAL AND OBSTETRICAL SOCIETY OF BALTIMORE.

OCTOBER MEETING.

The President, Dr. T. A. Ashby, in the chair.

Dr. J. Mason Hundley read a paper upon IMCOMPLETE ABORTIONS, of which the following is an abstract:

He uses the finger in all cases of incomplete abortions to remove adherent secundines, etc. Where, after exploration with the finger, there is found only small portions of tissue, he sees no objection to the use of the curette. But when called to a case of incomplete abortion he has universally found that the finger can be used with ease and efficiency where there is an appreciable amount of tissue retained within the uterus. The practice of blindly curetting a puerperal uterus without knowing the condition within its cavity can not, in his judgment, be too strongly condemned. There is a condition of the uterus mucous membrane following incomplete abortions where the only symptom present is hæmorrhage, with the uterus about its normal size or but slightly enlarged. If the uterus be curetted there will be gotten away very minute particles of tissue. This class of cases does not come strictly under the head of incomplete abortions.

He cited several cases where the operators had attempted to curette uteri containing adherent placental tissue; the hæmorrhage continuing, another operator was called in and when the finger was introduced in the uterine cavity it was found filled with fœtal remains. These cases, with many others, prove to his mind that it is impossible to appreciate the amount of retained tissue in a puerperal uterus at the end of a curette. He further believes that the laceration induced by the curette in these cases adds greatly to the danger of septic infection which can easily be made clear. Suppose after a curettement there remain pieces of tisue, as is often done, these pieces will undergo decomposition. With a lacerated surface, which we have where we scrape blindly about in a puerperal uterus, absorption can and certainly does occur more readily.

Then another danger is the liability of penetrating the uterine wall. As it is done in the non-puerperal uterus it seems to him very much easier of accomplishment in one that is soft and yielding, as is found in these cases.

Dr. Thomas A. Ashby: I think this is a very important subject. I have had three cases in the last three weeks. In the last eighteen months or two years I have had, I think, from twenty-five to thirty cases in consultation and in my own work. I have used the finger to remove what was left behind when it was possible to do so, but in many cases it is impossible and in these cases I have used the curette and have not found the curette dangerous, but have found it very efficient. I think there is some danger when great force is used, but I have had no trouble and can recall no case where the patient has had pus tubes or other septic trouble as the result. I have used the curette in septic cases and the temperature fell at once. I have met with no patients injured by other operators,

My method is first to wash out the vagina with a bichloride solution, then curette and wash out the uterus cavity with a 1-5000 or 1-1000 bichloride solution. All my cases have recovered.

Dr. J. Edwin Michael: It is difficult for me to fix my position when two extremes are presented as they have been here to-night. I think I can take a middle ground. The small curette is not only dangerous but is inefficient. The large curette is not dangerous and it is very efficient. I use it frequently and I think I can tell the difference between the uterine wall and placental tissue with the curette, and I also think you can clean the uterine wall more thoroughly with the curette than with the finger. If the staff of the curette is of some malleable metal, as it should be, you can so change the position as to reach all parts of the uterine wall. It is sometimes impossible to get the finger all over the uterine wall.

Dr. Thomas Opie: I do not remember to have had a bad result from the use of the curette in abortions. It is unnecessary to cut away any of the wall of the uterus with a sharp curette in early abortions, since as yet the attachments of the ovum are not strong and the rule is, it comes off intact. Thomas' dull wire curette is most suitable in such cases. Ergot does more harm than good. It promotes tonic contraction of the cervical sphincters and useless delay is occasioned in awaiting its action. All delay is wrong. Abortions when inevitable should be regarded as demanding immediate operative removal, since the two dangers, hæmorrhage and sepsis, confront us. The finger is safest but does not succeed in all cases; the same may be said for the curette. When both of these methods fail, we can resort to the parallel bar dilator. The cervix having been properly dilated, the curette can be successfuly resorted to in nearly if not all cases. These dilators are required latter in pregnancy, after the placenta is more fully formed and more difficult of detachment. Here the sharp curette is often best for the removal of the strongly adherent parts of the placenta.

Dr. William P. Chunn: I did not hear Dr. Hundley's paper, but from the discussion I infer that in some cases he is opposed to the use of the curette. I have used that instrument frequently and so far without objectionable results. The curette, to be effective, should be adapted to the size of the cavity of the uterus. In treating a case of incomplete abortion where dilatation is needed, the question arises, What is the best way of opening up the cervix? Where the cervix is soft a mechanical dilator may be best. If the cervix is hard a tent would soften and dilate better. I prefer to use a tent as large as possible, as a single tent is easier to clean and introduce than a number of smaller ones.

WILLIAM S. GARDNER, M. D.,
613 Park Ave. Secretary.

Coming-of-age festivities of a remarkable kind were celebrated at Whitmarsh, near Leamington, England, on November 13th. Twenty-one years ago the wife of a cattleman, the mother of thirteen children in all, gave birth to triplets. All three lived, and on November 13th they attained their majority. It is stated that a case of a triplet reaching the age of twenty-one is unprecedented in England.

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BALTIMORE, JANUARY 13, 1894.

Editorial.

THE INTRAVENOUS INJECTION OF SALINE SOLUTION IN CASES OF SEVERE HÆMORRHAGE.

The method of transfusion of blood has been attended with so many disadvantages and dangers, that it has become almost obsolete in practice. The best substitute for transfusion has been found in the intravenous injection of a saline solution.

Recent clinical testimony goes to prove that the injection of saline solution into the vein of one who has lost a large quantity of blood is followed with most excellent results. It has been shown by experiment that an injection of saline solution into the veins of an animal bled to apparent death would revive it and that recovery would take place.

At a recent meeting of the Obstetrical Society of London, Dr. C. Horrocks read a paper in which he reviewed the advantages of the saline solution as demonstrated by cases of alarming hæmorrhage in which the method was used. The following propositions were first laid down: (1) When a person is dead, from rapid hæmorrhage, there is still in the body sufficient blood to carry on life, if it can be circulated; (2) theoretically, half the volume of blood could do the same were it given double the velocity; (3) death from hæmorrhage is due to failure of the heart, and this is due to want of extension, owing to the fall in the blood pressure; and (4) this blood-pressure can be raised, if as much fluid be transfused as there has been blood lost.

The intravenous injection of a saline solution would seem, upon theoretical as well as upon practical grounds, to meet the above indications, and in point of fact, in six cases of hæmorrhage reported by Dr. Horrocks, such was the case.

The quantity of saline solution used in each case varied, according to indication, from 3 to 6 pints, the solution consisting of a drachm of salt to a pint of water.

Dr. Horrocks offered the following suggestions: (1) Transfusion of blood is useless and probably injurious; (2) water, with or without salt, should always be used; (3) the amount injected should always equal as far as possible the amount lost; (4) enough should be injected to make the pulse felt at the wrist; (5) the worst cases require six pints; (6) no case should be allowed to die from hæmorrhage without an attempt being made to save life by tranfusion; (7)

in less severe forms of hæmorrhage, where the patient is in a low condition but is not pulseless, injection of from two to five pints of saline fluid should be given to avoid secondary syncope; (8) and in the more moderate cases each one must be judged on its merits, but when in doubt it is better to inject fluid. Many of these, however, will rally by copious water injections into the cellular tissue between the shoulders and other parts, and into the rectum.

In the discussion of Dr. Horrocks' paper some interesting facts were brought out. It was shown that an intravenous injection is a comparatively simple and harmless procedure. The right median basilic vein was usually selected. The solution should be made of sterilized water and have a temperature between 98° and 100°. One of the speakers remarked that he carried in his obstetric bag sterilized sealed glass tubes containing two drachms of sodium chloride in solution ready for immediate use.

The method is one of more than usual importance and should commend itself to most careful consideration.

THE USE OF OPIUM IN INDIA.

The evidence submitted by the Opium Commission has served to remove much of the misunderstanding which has existed in regard to the use of opium by the people of India. Popular belief has reveled in the fancy that the population of India was so enslaved by this drug that these people were a race of dreamers. The evidence of the Commission has served to throw great light upon the subject. It now appears that the use of opium is the exception and not the rule; that the amount used by the opium habitué is far less than was assumed and that the effect is far less injurious.

The manner of use of the drug differs. In China opium is usually smoked. In India it is almost universally eaten, though numerous preparations are made by the people. The usual form consists in taking it in pills.

The opium-eater usually begins with a dose of ¼ or ½ a grain, which is gradually increased until 2 to 4 grains three times a day become the maximum quantity. In very rare instances is this exceeded, but in these individuals the quantity consumed ranges as high as 80 grains in 24 hours. The evidence shows that less than 2 per cent. of the population are addicted to the use of the drug. It thus appears that opium is far less frequently used by the people of India than is alcohol or tobacco by the population of this country and that its effects are far less injurious than either of the last named articles. Much evidence has been offered to show that the moderate use of opium not only does no apparent harm, but is actually beneficial under many conditions.

Its immoderate use in India and in other countries is so rare that it bears no comparison with the immoderate use of alcohol in its harmful effects.

The *Lancet* states that according to the records of the Oriental Life Assurance Company for the last twenty years there was not a single death attributable to the use or abuse of opium, of 973 death claims since 1874, and the company has on its books something like 20,000 native assurers. It is also a notorious fact that Sikhs and Rajputs, the bravest and most energetic races of India,

are very largely addicted to the use of opium.

The *Lancet* suggests that the thoughtful people of England should hesitate before they suppress the use of opium in India and encourage thereby the importation and consumption of alcohol.

The practical results of the Opium Commission investigations conclusively prove that the use of opium in India is not nearly so harmful to the people of that country as is the use of alcohol or tobacco to the population of England.

Reviews, Books and Pamphlets

The Principles and Practice of Surgery. By JOHN ASHHURST, JR., M. D., Barton Professor of Surgery and Clinical Surgery in the University of Pennsylvania, Surgeon to the Pennsylvania Hospital, Philadelphia. New (6th) edition, enlarged and thoroughly revised. In one octavo volume of 1161 pages, with 656 engravings and a colored plate. Cloth, $6.00; leather, $7.00. Philadelphia: Lea Brothers & Co., 1893.

The popularity of this well known work is shown by the demand for this new sixth edition.

The volume is a comprehensive description of modern surgical principles and practice. The entire work has been revised so as to bring it in accord with the present state of knowledge in surgery. The author has been assisted in the work of revision by a number of well known writers, among whom we recognize Naucrede, Hirst, De Schweintz and Randall.

As a text-book for students, Ashhurst's Surgery will continue to hold the eminent position accorded to it during the past twenty years.

New Truths in Ophthalmology as Developed by G. C. SAVAGE, M. D., Professor of Ophthalmology in the Medical Department of the University of Nashville and Vanderbilt University.

This little book of 152 pages is a collection of papers which the author has published from time to time in different medical journals. Dr. Savage is one of the thinking men of the profession, and there is a great deal of interest and usefulness to be found in this work.

Stearns' Calendar for 1894 has been received. The Christmas greeting which Frederick Stearns & Co., Detroit, Mich., are sending to their customers is of a character which far exceeds the many elegant expressions of good wishes which this firm sent out in former years, and is of exceptional interest on accouut of the introduction of a new feature in pictorial art, one to which much scientific research and effort have been directed during late years—that of photography in original colors. Stearns' calendar for 1894 is, we believe, the first example of the application of this new process which has been offered to the public, and as such it possesses an interest aside from its artistic value. As regards the latter, however, a happy selection has been made in the reproduction of "The Rivals," by F. P. Michetti, a subject in which is included the inimitable coloring which nature gives to a pleasing landscape with that of two gaily costumed peasant girls whose graceful attitudes suggest the title of the picture.

The details which attend the process are referred to at length in a small folder which accompanies the calendar. The supply is necessarily limited, and duplicates can only be furnished upon receipt of 25 cents to cover actual cost of production, postage and packing.

A Dictionary of Medical Science. With a full explanation of the various subjects and terms of anatomy, physiology, medical chemistry, pharmacy, pharmacology, therapeutics, medicine, hygiene, dietetics, pathology, surgery, bacteriology, ophthalmology, otology, laryngology, dermatology, gynecology, obstetrics, pediatrics, medical jurisprudence and dentistry, etc., etc. By ROBLEY DUNGLISON, M. D., LL. D., late Professor of Institutes of Medicine in the Jefferson Medical College of Philadelphia. Edited by RICHARD J. DUNGLISON, A. M., M. D. New (21st) edition, thoroughly revised, greatly enlarged and improved, with the prouunciation, accentuation and derivation of the terms. In one magnificent imperial octavo volume of 1181 pages. Cloth, $7.00; leather, $8.00. Philadelphia: Lea Brothers & Co., 1893.

For sixty years this work has been recognized as the standard authority on the subject of which it treats. During this period twenty-one editions have been issued by the publishers.

These editions have been made necessary to meet the ever increasing demand for new words and phrases in medical terminology.

In the present edition no less than 44,000 new additions have been made. The work is too familiar to demand a word of commendation from us. Its value is so well understood that no physician's library can dispense with it. It will be found of equal value to the dentist and pharmacist.

The Columbia Desk Calendar, which is issued annually by the Pope Manufacturing Company, of Columbia Bicycle fame, is out for 1894, much improved in appearance. It is a pad calendar ofthe same size and shape as those of previous years, having a leaf for each day, but its attractiveness has been heightened by the work of a clever artist, who has scattered a series of bright pen-drawings through its pages. It also contains, as usual, many appropriate and interesting contributions from people both bright and wise.

Medical Progress.

THE VALUE OF TUBERCULIN AS A TEST FOR TUBERCULOSIS IN CATTLE.

Probably few physicians are aware of the enormous practical value in the animal industry of tuberculin; that is to say, if the position taken by the New York and other State Boards of Health regarding it is correct. A gentleman who has a valuable herd of thoroughbred cows writes us that twice in the last six months his herd has been examined by competent veterinarians and pronounced healthy. A third examination, however, with the aid of tuberculin, caused a condemnation of over one-half the herd. He adds:

"The New York State Board of Health is killing by the hundred animals

condemned by diagnosis with tuberculin and the State is paying full value for them. The veterinarian says that the autopsy shows the diagnosis to be correct in every case. He says also that it is impossible for the best veterinarian to discover tuberculosis by physical examination except in extreme cases. My herd is apparently in splendid condition. Breeders do not know of its existence in their herds. They let a cow remain in the herd until she is unquestionably tuberculous and then remove her, but she has then already infected the herd. A temperature of 103° F. condemns the cow. In a herd of Jerseys, at Troy, of 80 head, he has killed 33, and will kill 20 more of them this week. Autopsies are held in the presence of physicians and veterinarians. There have been 15,000 tests with tuberculin in England. New York evidently believes in this kind of diagnosis, and will probably have to pay $500,000 to eradicate tuberculosis. The veterinarian says the State is full of it in herds both of thoroughbreds and common cows."

We understand from other sources that the State Board of Health fully believes in the certainty of the tuberculin diagnosis. Through its means it has been discovered that some of the best bred herds, supplying high-priced milk, cream and butter, are infected.

THE PROGRESSIVE DOCTOR.

The progressive doctor is the product of the nineteenth century, and is a thoroughly live man. He is well informed on most medical topics because he is a wide reader, and is not narrow in his views. He likes to hear all sides of every question, whether opposed to his ideas or not, because he knows that the truth is generally found *in media res*.

The number of medical journals which litter his desk, and the frequent communications which appear over his signature show that he realizes the importance of keeping his mind in touch with the medical world.

The respect shown for his opinions is an evidence that he has the courage of his convictions, and does not hesitate to do what he thinks best, regardless of custom or authority.

Bitter experience has taught him the fallacy of that old axiom upon which the professor of theory and practice always lays so much stress, namely, that, if you learn to diagnose diseases correctly, any fool can treat them. He has learned that ultimate medical progress is in direct ratio to increased knowledge of therapeutics. He remembers numerous occasions in his practice when, secretly confessing to himself his utter inability to make a rational diagnosis, he has given certain remedies upon general principles and brought a perplexing case to a successful issue.

He holds fast to the remedies which have served him in the past, but does not fail to try the new ones which appear from time to time. He knows that his duty to his patient requires him to see that the latter gets pure drugs, and he does not fail to inspect his prescriptions after they are filled, nor to recommend a druggist whom he knows to be honest and reliable. He is careful to look after the minutiæ of his business, recognizing the importance of detail in the care of the sick.

Lastly, he is a perfect Christian gen-

tleman—a man of undoubted integrity, caring little for creeds, codes or legislation, knowing that the unwritten law of the conscience is a severer judge than any instrument framed by man.

Men such as these the profession delights to honor. They constitute that liberal leaven, which, slowly working, will, at last, make medicine one grand universal science.—*Medical Brief.*

HYDRASTININE IN UTERINE HÆMORRHAGE.

Gottschalk says hydrastinine may be employed:

1. First of all, in those uterine hæmorrhages which are traceable to a pronounced congestion of the uterus. To these belong, above all, the often very profuse menorrhagias of spinsters, in whom there is no pathological change in the condition of the genitals. In some of these cases it is possible to obtain a permanent result, so that even after discontinuing the remedy the menstrual flow remains smaller.

2. Also in hæmorrhages which have their pathological and anatomical cause in endometritis, hydrastinine will lessen the quantity of blood; but here, according to Gottschalk's experience, the action is only palliative, not being sufficient alone to cure the local cause of the trouble.

3. For prophylactic or inter-menstrual use, hydrastinine is useful before or during the first returning profuse menstruation after an abrasion of the uterine mucosa. It is well known that this menstruation, usually occurring after six weeks, is often very profuse. In the very cases where there was a great loss of blood before the operation, it is of great importance to prevent further profuse hæmorrhage. This is impossible if the treatment with hydrastinine is begun several days before the expected menstruation, and, if necessary, continued during the duration of the menstruation.

4. Menorrhagias caused by retroflexio uteri are best treated by correction of the malposition; but for cases of fixed retroflexion, where the reposition is not yet possible, hydrastinine is a commendable remedy.

5. Secondary uterine hæmorrhages—*i. e.*, those caused by a change of the adnexa and their surroundings—offer a large field for the successful use of hydrastinine. To these belong the menorrhagias and metrorrhagias with pyosalpinx, oöphoritis, ovarian tumors and exudations. Of course the cause of the trouble is not influenced by the remedy.

6. Climacteric menorrhagias are much diminished by a faithfully carried out hydrastinine treatment.—*Brooklyn Medical Journal.*

TOO MANY MEDICAL SOCIETIES.

We are suffering in this country from too many medical societies. The recent meeting of the Northeastern Ohio Medical Association in this city is a good illustration of the amusing phenomenon of the city specialist reading papers to the country practitioners without the presence of the country practitioners. While many of the district medical societies in Ohio are doing good work and are most creditably conducted; yet it must be conceded that these societies are conducted and supported to the detriment of the country and State societies. It is also a lamentable fact that some of these societies are directly and openly antagonistic to the

local and county societies, and thus do great harm. Another phase of this tendency to create innumerable medical societies was the recent second annual meeting of the Ohio State Railroad Surgeons, in this city. The meeting was announced with a great flourishing of trumpets and a most formidable appearing program covering three days. Notwithstanding all the newspaper notoriety and other advertising, only a handful of railroad surgeons was present, and all the business of the meeting was transacted and papers read in two short sessions. But this is only an example of the tendency to form district, State, tri-State, National, and every other possible excuse that can be thought of to organize new societies. The men who organize and run and get all the eclat and offices and free advertising from these societies, are not as a rule, the men of real scientific ability, and not usually the men who are respected by their fellow workers at home. In fact, they are too often the men who are in bad odor and who do not hold the esteem and respect of those who know them best, and consequently are obliged to go away from home, where they are not known, in order to secure these positions of honor. Not infrequently these men manipulate the State and National organizations for their own purposes, as long as possible; and when they are found out and turned down, they go off and organize a new society. And the pity of it is that the respectable, well-meaning, intelligent, scientific practitioners will go into these new organizations and lend to them a certain respectability; and in fact, without the labors of these unselfish members of the profession, they could not and would not exist.

Consequently it is of great importance for every one to carefully investigate the claims for existence which every new society has upon the profession, before lending it support. If properly conducted, the county, State, and American medical associations would fulfill all the requirements of medical organizations of a State or National character; and in larger towns, one or more local societies would meet all the necessities of the case. By dividing the work into sections, as is done in large Eastern cities, many of the local societies might be dispensed with. As a matter of fact the great bulk of the work will be done by a limited number of individuals, no matter whether there is one or a dozen local organizations. The same is true of district, State, tri-State and National organizations; but the disadvantage of having a multiplicity of societies is much greater in the larger bodies. It is becoming impossible for a man to attend all the medical societies he might wish to, as at present organized.—*Cleveland Medical Gazette.*

MICROBIC ORIGIN OF CHOREA.

Charles L. Dana, M. D. (*American Journal of Medical Sciences*), says:

There is a meningitis of the cortex which extends into and in places involves the cortex. It is characterized by an active connective tissue proliferation and the presence of diplococci in the meninges and cortex. In the cortex are small hyaline bodies which indicate a degenerative change of the brain substance. This degenerative change affects the deeper parts of the brain to a

less extent, extending down into the capsule and lenticular nucleus, but not the optic thalamus. There is a meningitis with active vascular changes in the upper part of the cord which seems particularly to surround and affect the roots of the nerves as they leave the medulla and the cord.

It seems to me that the teachings of this case are very important in many ways. First of all, it shows us that there is a close relationship between many of the chronic spasmodic disorders of irregular type and the chorea of Sydenham. Secondly, it confirms the view already generally accepted, that chorea is a vascular and humoral disease. Third, it gives weight to the belief held by many that there is, in some cases at least, a microbe which produces this disease. Fourth, it shows that in these cases the seat of the lesion is either meningeal or superficially cortical so far as the brain is concerned, and that as regards the spinal cord the seat of the lesion is mainly in the meninges and bloodvessels, where it apparently surrounds and irritates the roots of the nerves.

Finally, we cannot explain chorea by finding any particular *seat* of the disease, though the voluntary motor tract in the brain must at some point be involved.

Neither has chorea any special form of anatomical change invariably associated with it, though degenerative hyaline change and evidences of vascular irritation are most common.

There must be, in order to produce chorea, a specific kind of irritation of the cells. This need not be of one kind; it may be a rheumatic poison or a diplococcus toxin. But the specific irritants are not numerous, for though the motor fields undergo innumerable forms of injury and disease, chorea occurs but very rarely, and only when the proper regions are properly irritated. There is nothing which would explain the phenomena of the disease so well as to suppose that the specific agent producing chorea is a microbe, and perhaps some form of the diplococcus.

The various types of chronic chorea would be explained by the changes in the intensity of the irritation, its special localization, and the degree of organic change which it eventually induced.

THE NEW YORK SOCIETY FOR THE RELIEF OF WIDOWS AND ORPHANS OF MEDICAL MEN.

At a meeting of the board of managers held on December 20th, the president, Dr. Ellsworth Eliot, made the following remarks:

"Eleven widows and three children of deceased members relieved; $6,610.30 added to the permanent fund, now amounting to $189,157 06; the membership increased by thirteen, now numbering one hundred and forty-three; and all this at an expense of only $180.30—such is the record of the last year, and it will compare favorably with that of any preceding one.

"In its foundation our society had for its model that of the same name in London, established in 1788, and such are our record and prospects that the mother need not feel ashamed of the daughter. Of course their capital—£88,057 10*s.* 6*d.* (about $440.286)—greatly exceeds ours. They have had legacies from fifty-eight persons, three of £5,000 each ($25,000), one of these, and the

last of the three, being that of Sir Erasmus Wilson, the distinguished dermatologist, in 1887. Our benefactors number fifty-five, most of them having contributed $150 each. The name in this list leading all the rest is that of Alonzo Clark, whose gift is estimated at $20,000.

"According to the last publication of the London society, the allowance to a widow is £50 ($250) and a Christmas present of £5 ($25), making £75 ($275) for the year. The largest allowance to their orphans is £12 ($60) with a Christmas present of £2 ($10), making the annual amount £14 ($70). The provision in our by-laws for giving each child $50 as an outfit at the time when the annuity ceases I do not find in their regulations.

"Their expenses last year exceeded $1,200 (£247 3*s*. 10*d*.). Of this the secretary had $630 (£126). The amount of our expenditure, as above mentioned, is $180.30, our secretary being allowed 'an honorarium of $50.'

"Their 'grants and expenses' exceeded their 'total receipts available for payments' by £73 6*s*. 4*d*. ($366), this amount being their deficit. We added, as previously stated, $6,610.30 to our permanent fund. Happily, our by-laws prohibit deficits. Their membership is three hundred and twelve—seven less than the previous year. The number of their widows receiving relief is fifty-eight, and the number of children twelve. The large number of the former is astonishing. Should our widows ever bear as large a proportion to our membership as is the case with the London society, we should be compelled to reduce the allowance, or gifts to our principal must be large and numerous.

"A great difficulty during the past year has been the safe investment of our funds at a fair rate of interest. We have had thousands of dollars for which we received but two per cent.

"The secretary of the London society informed me last summer that it required much effort to keep their numbers good and to make additions thereto. Such has been the experience of our society. For a number of years our members, according to the annual statements, were fewer and fewer. I believe that for several years not more than one or two persons have voluntarily sought membership. Those who have joined us have done so through personal solicitation. The energetic president of the New York Physicians' Mutual Aid Association, happily one of our board of managers, recently informed me that not more than six out of a hundred applied for membership in that society without personal urging. Printed documents and annual statements do not bring members. Physicians should make provision for themselves and any family they may leave. No one in our profession in our city need die in straitened circumstances. By the payment of from $15 to $20 in the Physicians' Mutual Aid Association, his representatives, in the event of his death, can immediately command $1,000. After a suitable probation and not a large payment in our society he can provide generous relief for a widow and orphans, should they be in need of it. The medical profession in no city in the world, so far as I can learn, are as fortunate in this respect as the physicians in generous New York.

"Our board of managers is much the same as last year. Two faithful ones, Dr. Laurence Johnson and Dr. William T. White, whom death has removed, we shall greatly miss. Happy will it be for the society if their successors prove equally attentive to their duties."—*N. Y. Med. Journal.*

SPECIALISM IN REGULAR COURSE.

Dr. Dudley S. Reynolds read a paper at the last meeting of the Association of American Medical College, Milwaukee, Wis., June 7th, 1893, on this subject.

In discussing Dr. Reynold's paper, Dr. David Streett, of Baltimore, said: We are not prepared to place in the catalogue of specialties the fundamental branches—anatomy, physiology, pathology, and materia medica; admitting they are special branches they are not *specialties* as usually accepted. We can claim as specialties only those branches bearing upon and describing the diagnosis and treatment of diseases, to which the former are necessary prerequisites, in yielding to the student indespensable fundamental knowledge. So many specialties in every department of medicine and surgery as now exist manifest a diminished influence and usefulness of the general practitioner and surgeon, rather than a broadening of medical science as a whole.

In the present state of our profession, we have specialists for every system, organ, and part of the body. May we not pertinently inquire, what is to be the future field of labor for practitioners? The existence of so many specialists and specialties shows a demand, *not* for more *specialists*, but for better educated physicians, who shall be better qualified to render scientific and rational clinical services as required in the present era of human progress.

With the formation of such a class of physicians, their influence and usefulness will increase; the general tendency to specialism will cease; and specialists will be disproportionally diminished in number.

Specialism will then probably be confined to such branches as "The Eye and Ear," "Nose and Throat," and other fields generally admitted to require special qualifications, delicate manipulation and dexterity.

Can we, with the present college curriculum, completed in three terms of six months each, develop such physicians? To do so will require more thorough instruction in a more liberal curriculum than is now usually found.

Specialists cannot be made in our medical colleges; they must be developed by additional education and practice, in post-graduate schools or polyclinics, at home or abroad. If the medical colleges of the present cannot develop the *ideal* physician, let us do the best we can under the circumstances. Let us give more instruction on practice of medicine, surgery, and obstetrics, and proportionally less on special subjects. Then we will graduate better educated physicians, who will be better qualified to diagnose and treat diseases.

Some of these well-rounded physicians will pursue post-graduate courses and become specialists; and they will be able in their respective branches, because the superstructure of their knowledge is supported by a sound and comprehensive medical education.

In this era, so prevalent is the desire

of students to become specialists, that many of them, while pursuing the regular course of study, and before they have completed the fundamental branches, avow their determination to become specialists; if permitted they will pursue special instructions while undergraduates.

It is unnecessary for me to say such course should not be permitted or encouraged.

I am of the opinion that in many medical colleges, too much time, proportionally, is devoted to special branches, and too little to the major branches. *Two* lectures per week on each specialty are frequently given, and only *three* on major branches like practice of medicine, surgery and obstetrics. Two-thirds as much time is thus devoted to teaching each *special* branch as is given to each general branch.

Students are taught minutiæ of *special* branches before they have comprehended the general branches; they are required to construct the roof of the temple before the walls thereof have been completed.

Of the large number of graduates, comparatively few become specialists. Some special branches are rarely or never practised by the general practitioner.

Why, then, require of students so much time and study on branches which practitioners rarely pursue, when such time, in a short college term, is deducted from that required for fundamental and other important branches?

It is a misappropriation of valuable time; a misapplication of much study. Sufficient time should be devoted to special subjects, during the regular course, to enable students to comprehend their most important principles and facts; as much time and study as is consistent with a thorough knowledge of the more important branches. Such instruction will not qualify them as specialists. Why, then, require for their study so much time, which can be more profitably applied to general medicine and surgery?

Practitioners should be taught a regular course in medical colleges; to become specialists they should receive special post-graduate instruction.

Recognition of such principles and a corresponding regulation of time and study will result in the graduation of better physicians, the formation of better practitioners; in greater good to mankind and glory to our profession.

Correspondence.

Ellicott City, Md.,
Jan. 11th, 1894.

Editor Maryland Medical Journal:

I beg leave to report the organization of the Baltimore Neurological Society, completed January 9th, 1894. At call of Dr. George Rohe, those named below met at the Maryland Hospital for the Insane at 7 P. M., January 9th. Dr. Hurd was called to the chair. The object of the meeting was most carefully set forth by Drs. Rohe, Hill and Brush. These gentlemen were forthwith made a committee to draft a constitution which was dully presented and generally adopted after some little discussion.

It was decided to make the monthly meetings partake of a social nature, as well as the more serious consideration of

matters pertaining to psycho-pathology and neurology, that the membership be limited to medical men especially engaged in the practice of psychiatry and neurology, and medical men who are official members of boards of lunacy or of the managing boards of hospitals or institutions for the insane or feeble minded, in the State of Maryland. It was decided to hold the next meeting at the Johns Hopkins Hospital, February 14th, Dr. Hurd to preside.

Those present were, Drs. H. M. Hurd, H. J. Berkeley, Geo. J. Preston, Chas. G. Hill, Wm. Lee, E. N. Brush, F. J. Flannery, R. H. Gundry, J. P. Wade, J. N. D. Norris, W. L. Babcock, F. M. Clarke, H. M. Thomas, Geo. H. Rohe; T. W. Clark, Samuel J. Fort.

A collation was served at 9.30 P. M., after which, there being no further business before the society, it was adjourned.

SAMUEL J. FORT, M. D.,
Secretary.

Medical Items.

At the University of Moscow, the fees for the curriculum of five years amount to only £80.

Dr. Bacelli, Professor of Medicine in the Faculty of Rome, has been appointed Minister of Public Instruction.

Gov. Flower, of New York, on December 28, announced the following appointments to the State Board of Health: Henry G. Wolcott, of Matteawan, to succeed Thomas Newbold; Dr. John Edwards, of Gloversville, to succeed Dr. Dawes, of Saugerties; Dr. Murray M. Adams, of Watertown, in the place of Prof. Perkins.

The total number of students in the university of Greifswald, this current semester is 757, of whom 380 belong to the Medical Faculty.

The dedication of the New Medical College building of the Tulane University took place November 4, 1893. The building is composed of three connected buildings. The centre one contains principally the lecture room, having over it the amphitheatre and two wings which contain the laboratories, dissecting-rooms, and museum. The basement is well lighted, and contains a study-room for students, a recitation-room, and an embalming room. The microscopical, chemical, pathological, bacteriological, and pharmaceutical laboratories are supplied with the latest improvements, and form one of the most complete medical institutions in this country.

The 28th Anniversary Banquet of the Baltimore Medical Association was held on Monday, January 8, at 9.30 P. M.

The following officers were elected for the ensuing year:

President, Dr. David Streett; 1st Vice-President, Dr. H. H. Biedler; 2nd Vice-President, Dr. E. D. Ellis; Recording and Reporting Secretary, Dr. Eugene L. Crutchfield; Corresponding Secretary, Dr. J. D. Farrar; Treasurer, Dr. J. L. Ingle; Executive Committee, Dr. John I. Pennington, Dr. Stephen Crowe, Dr. J. Edwin Michael; Committee of Honor, Dr. Geo. J. Preston, Dr. Chas. H. Jones, Dr. John W. Chambers.

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Original Articles.

ELECTRIC ILLUMINATION OF THE STOMACH.[1]

BY JULIUS FRIEDENWALD, A. B., M. D.,

Demonstrator of Pathology, College of Physicians and Surgeons, Baltimore; Visiting Physician to Bay View Hospital; Attending Physician to the Medical Department City Hospital Dispensary.

In 1867, Milliot[2] invented an instrument to illuminate the stomachs of dead human bodies and of animals. Trouvé,[3] in 1869, constructed his polyscope, through which he obtained a view of the stomach; this has been used on animals to demonstrate the process of digestion.

In 1883, Mikulicz[4] used a similar apparatus, the gastroscope, on the human being. This consists of a metal tube through which the interior of the stomach can be viewed. He was thus able to diagnose pyloric cancers by the peculiar smooth appearance of the gastric walls. The introduction of the apparatus, however, was attended with such difficulty that it could never be used for practical purposes.

Einhorn,[5] in 1889, published the first report of his instrument, the diaphane, by means of which he could transilluminate the walls of the stomach.

The apparatus of Einhorn consists of a soft rubber tube having an Edison lamp fastened at one end enclosed in a glass cap; within the rubber tube are wires connecting the lamp with a storage battery; at the other end of the rubber tube is an interrupter. Einhorn's directions are to have the patient, who is in a fasting condition, drink one to two glasses of water and then to insert the apparatus, lubricated with glycerin. The patient is examined in a dark room,

1. Demonstration before the Clinical Society of Maryland, January 5, 1894.

standing; the stomach appears as an illuminated reddish zone on the abdominal wall. From the use of the apparatus Einhorn derived the following conclusions:

1. We are enabled to recognize quickly a dilatation of the stomach.

2. The condition called gastroptosis can with certainty be pointed out.

3. One is enabled to perceive tumors or thickenings of the front wall of the stomach by their lack of tranparency.

We distinguish variations in the size, the location and also in the intensity of the illumination.

In cases of dilatation the lower part of the illuminated area (lower zone) is of a very bright red color and reaches below the umbilicus, often to the symphysis pubis; it passes over into a less intense zone above the umbilicus.

Since Einhorn's first publication, Heryng and Reichmann [6] have transilluminated the stomach and also the colon with a special apparatus of their own construction.

This instrument contains, in addition to the Einhorn diaphane, a coil in which water circulates, which keeps the lamp cool. These investigators recommend the introduction of large quantities of water into the stomach—one to one and one-half liters, instead of the small quantities, one to two glasses, as recommended by Einhorn.

Numerous other investigators have demonstrated and reported the special advantages, in certain cases, of the diaphane. Among these are Parise, [7] Renvers,[8] Boas,[9] Ewald[10] and Einhorn,[11] Stewart [12] and Solis-Cohen, [13] in this country.

Kuttner and Jacobson,[14] working under Ewald's direction, were the first to make a systematic study of gastro-diaphany upon a large number of cases and to verify their results by post-mortem examination.

Their results agree in general with those obtained by Einhorn. Their clearest pictures were obtained when the stomach contained a large quantity of water—*i. e.*, one liter. They lay stress on the respiratory movements of the illuminated zone (in inspiration descent, in expiration ascent) in those cases in which the stomach is in direct apposition with the diaphragm.

In gastroptosis (dislocation of the stomach downward) there is no respiratory movement of the luminous zone, while in dilatation this change is very manifest.

My best results have likewise been obtained when the stomach was filled with water and my observations confirm the above statement concerning the changes in position of luminous zone during inspiration and expiration.

The instrument is introduced after moistening with a little water; the use of glycerin and other lubricants is unnecessary.

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2. Milliot, Paris, 1867.
3. Trouvé, see New York Med. Journal, May 28, 1892.
4. Mikulicz, Ueber einen geheiten Fall von Magenresection nebst Bemerkungen ueber ein gastroscopisches Symptom des Magencarcinoma.
5. Einhorn, New Yorker Medicin. Monatsschrift, November, 1888; also Berliner Clinis. Wochenschrift, 1892, No. 51; also American Medical Journal, Dec. 3, 1892.
6. Herying und Reichmann, Ueber electrische Magen und Darmduchleuchtung Therap. Monatsh. Marz, 1893.
7. Pariser Berliner Med. Gesellschaft, July 6, 1892.
8. Renvers, Verein fuer Innere Medicin, Berlin, April 4, 1892.
9. Boas, Specielle Diagnostik und Therap. der Magenkr., Leipzig, 1893, pages 86. 87, 105.
10. Ewald, Klinik der Verdanungskrank II, 3rd Ed., 1893, page 91.
11. Einhorn, on Gastrodiaphany, Medical Journal, Dec. 3, 1892, and The Journal, July 8, 1893.
12. Stewart. A Resumé of Some Modern Methods of Diagnosis, Medical News, Feb. 18, 1893, page 170.
13. Solis-Cohen, College of Physicians and Surgeons, Phila., New York Med. Journal, Dec. 16, 1893, p. 744.
14. Kuttner and Jacobson. Ueber die Electres. Durchleuchtung des Magens und deren diagnostischen Verwerth barkeit, Berl. Klinisch Wochenschrift, Sept. 25 and Oct. 2, No. 39 and 40, 1893.

Fig. 1.—The Gastrodiaphane.

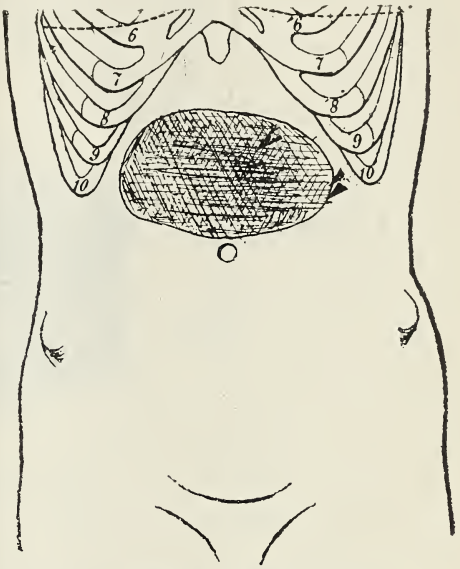


Fig. 2.—Case J. T.

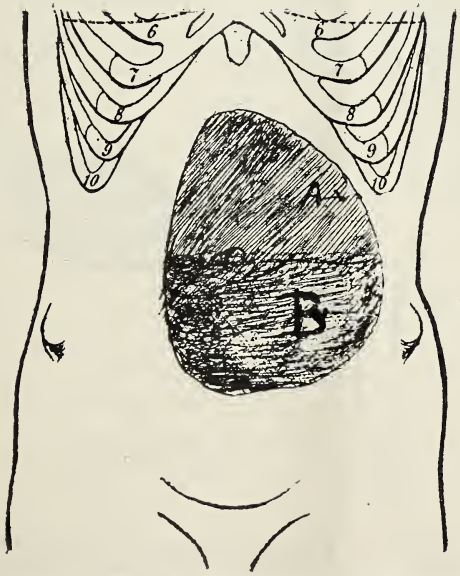
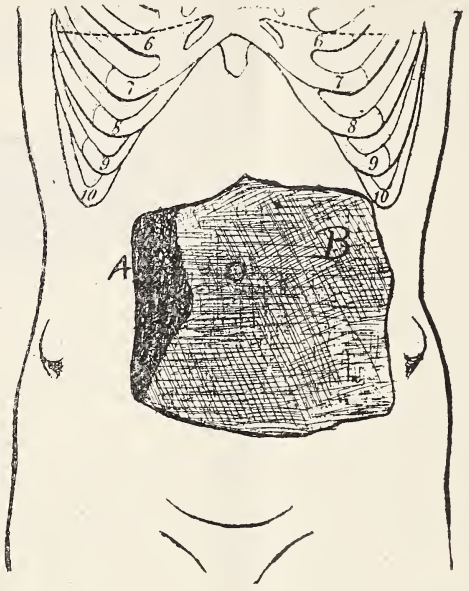


Fig. 3.—Case J. S., Dilatation of the Stomach.

A—Tumor.



B—Luminous Zone.

Fig. 4.—Tumor of Pylorus. (From Kuttner and Jacobson, Berlin Klin. Wochenschrift, No. 4, 1893, p. 970.

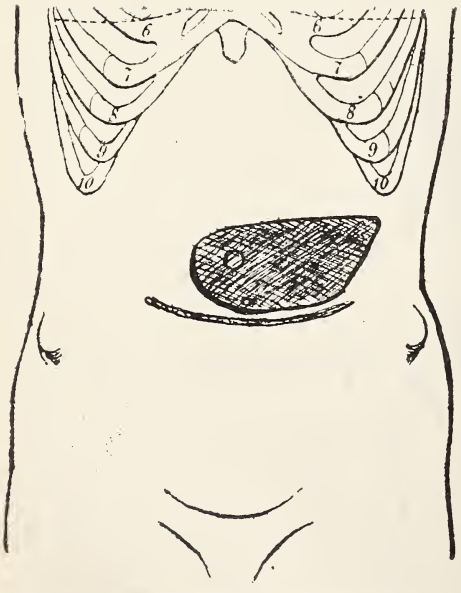


Fig. 5.—Gastroptosis (Deep Inspiration). Case Miss A. (Downward Dislocation of Stomach).

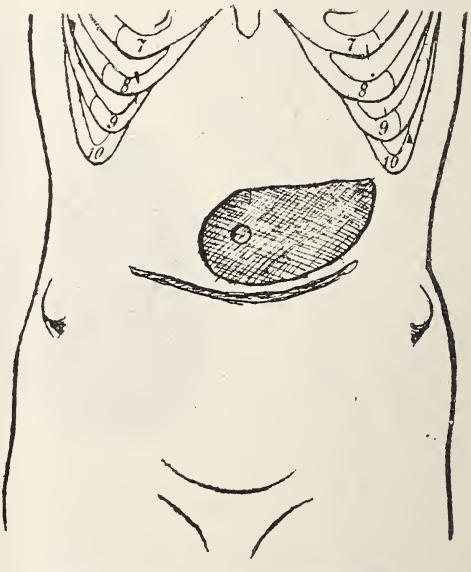


Fig. 6.—Gastroptosis (Deep Expiration). Miss A. (Downward Dislocation of Stomach).

TUMORS OF THE PERIPHERAL NERVES; WITH THE REPORT OF A CASE OF SARCOMA OF THE SCIATIC.*

BY THOMAS S. K. MORTON, M. D.,
Professor of Surgery in the Philadelphia Polyclinic.

All tumors growing in or upon peripheral nerve trunks have come to be classed as neuromata, and of these two general divisions are made—the true and the false. The true neuroma is composed of nerve elements, while a false neuroma is a tumor developing in connection with a nerve or its sheath, but not composed of nerve elements. Virchow has proposed that only true nerve tissue growths be called neuroma, while other tumors growing in connection with nerves shall receive the same name as would similar neoplasms occurring elsewhere. This more simple and accurate method of classification has not, however, been followed generally by writers.

Fibroma is the common tumor found in connection with nerve trunks, and is usually composed of white fibrous material with few connective-tissue cells. Plexiform and multiple neuromata are usually congenital and often hereditary, slowly growing varieties where a number of nerves undergo a fibrinous change and occasionally form plexes of sensitive interlacing cords. The subcutaneous terminal extremities of sensory nerves may undergo fibrous changes and form the so-called "tubercle dolorosa." According to Bowlby,† sarcoma is next in order of frequency. "They may belong to the round, oval, or spindle-celled varieties. In such growths, especially in those which increase most rapidly in size, degeneration cysts may form so that the tumor may become partly filled with fluid. The contents of such cysts are usually blood and broken-down cells." Very rarely myxomas are met with. In these the mucoid material grows from the nerve sheath. Glioma, as may also be said of syphiloma, is all but unknown excepting upon the cranial nerves, and even upon these is almost never observed beyond the confines of the cranium. Two cases of simple cyst containing clear fluid, in connection with nerve trunks, have been recorded by Bowlby. I have found references to cases upon record as fibro-sarcoma, myxo-sarcoma, and cavernous sarcoma; also to "blood-cyst" of nerve trunks. The two latter, in the light of modern pathology, probably being instances of cystic degeneration of simple sarcoma. All nerve tumors show a marked tendency to malignant degeneration. Secondary or metastatic tumors of nerves are probably not uncommon. Probably more records of tumor of the optic nerve than all others put together are to be found in medical literature, but nerve-trunk tumors must be considered as rarities when judged by the very small number that I have been able to find reference to in the books and *Index Medicus*.

Diagnosis, before operation, except in the case of superficial neuromata, unless there are marked motor or sensory disturbances, is almost impossible in the majority of cases. Even these symptoms may be simulated by pressure upon the nerve by outside growths. It is a remarkable fact that most tumors of

*Read before the Philadelphia Academy of Surgery, Nov. 9, 1893.

†Injuries and Diseases of the Nerves. London, 1892.

nerves give rise to but trivial changes of sensation, and the conveying and trophic power of the fibres is almost never fully destroyed. When the tumor has actually been exposed by dissection, unless the surgeon is exceedingly careful, a nerve is liable to division or other injury before the true nature of the growth is discovered. Cases are upon record where excellent surgeons have not recognized the nature of tumors until the ensuing paralysis of function and the microscope have solved the problem.

Removal of those neoplasms which involve all of the bundles necessitates total divisions of the nerve trunk above and below the tumor; which should be followed, if possible, by immediate approximation of the ends by the employment of some one of the various methods of suturing, lengthening, or splicing and the subsequent placing of the parts by posture in that position which gives greatest relaxation to the nerve trunk involved. Where approximation is impracticable the ends should be "aimed" at each other by chromic catgut sutures, and regeneration with more or less restoration of function may be expected to slowly supervene in many cases. When the growth involves simply the sheath of a nerve, internally or externally, prompt recognition of its nature and relations, together with careful dissection, will prevent injury to the nerve itself. If the tumor is within the sheath—as in my case—a longitudinal division of the sheath without division of any of the nerve fibres will be sufficient to fully expose it. If then it is found to arise from a few of the nerve bundles, these may be divided and the growth shelled out of its bed, if possible, without rupturing the capsule if it possess one. Any small number of fibres that may be thus divided may be expected to regenerate and coalesce; larger bundles should at once be sutured with catgut. Subsequent suture of the divided sheath would appear to be a neat point of technique, but, as proved in the case here reported, is sometimes unnecessary. On the other hand, the possibility of hæmorrhage taking place within a tightly sutured sheath must not be lost sight of. Gowers is authority for the statement that excision of nerves on account of tumor is prone to be followed by the development of bulbar (traumatic) neuromata. This may have been true of nerve sections prior to the antiseptic period, but absence of suppuration, combined, as it often can be, with immediate suture, should render such results here, as elsewhere, very unusual.

The history of the case which has suggested these remarks is as follows:

Mrs. D. A., aged forty-two years, a Russian of the middle class, entered the Polyclinic Hospital October 3rd, 1893, with a tumor upon the back of the left thigh. Family history negative so far as could be secured. Physical examination, except the tumor, negative. Urine normal.

She stated that about one year previously she had accidentally discovered a small nodule deeply situated upon the posterior portion of the left thigh; that it had grown slowly at first, but during the past three months with increasing rapidity; and that, excepting inconvenience in sitting upon the mass, which gave rise to some pain, the tumor had caused little or no discomfort. No definite history of any sensory or motor

disturbance in the sciatic distribution could be elicited.

The growth was the shape and size of a large goose egg, with its long axis corresponding to that of the thigh. It lay exactly over the course of the great sciatic nerve, midway between the tuberosity of the ischium and the flexure of the knee-joint. It could be moved somewhat from side to side, but almost none at all upward or downward. It did not move when the posterior muscles of the thigh were exerted. To pressure and palpation the growth was almost insensitive. It felt like a soft fibroma or fibro-lipoma, but did not impart any sense of fluctuation.

On October 6th a careful dissection was made and the tumor exposed at the base of a six-inch incision. It was noted that each time the growth was impinged upon by the finger or an instrument the lower leg gave a sharp, convulsive start. When moderately cleared of its surroundings the fact that a neoplasm involving the sciatic nerve was to be dealt with was made very evident by observation that the fibres of that nerve could be seen as glistening white cords of varying size beautifully frayed or spread out as they ran around the growth through the encapsulating nerve sheath. A vertical incision, avoiding nerve fibres, was made to the full extent of the tumefaction through this apparent capsule, when it was further discovered that the tumor proper was entirely disconnected with the sheath, and was separately enclosed in a capsule within. The growth was readily separated from the sheath of the nerve in all directions except at points at the extreme proximal and distal extremities, where a few nerve fibres entered and emerged from it respectively. Some small bloodvessels appeared to acccompany the strands of nerve substance into the tumor. These fibres having been divided, the growth was lifted out without further difficulty. Upon examining the cavity in the nerve sheath from which it came it was observed that most of the bundles of the sciatic were in advance of, and had been spread out over the external surface of the growth, but that no appreciable injury had been done them with the exception of the few fibres which had necessarily been divided as they entered the tumor. No sutures were applied to the nerve sheath nor were any ligatures called for. The wound was closed without drainage by alternate deep and superficial silk sutures and a pad of dressing so applied as to make compression upon the cavity left by the tumor. The operation was followed for two days by some pain in the whole sciatic distribution, but especially in the region supplied by the external popliteal, but no loss of power ensued. All pain disappeared in forty-eight hours, however, and afterward she had no disagreeable sensations. Upon the seventh day all sutures were removed and absolute primary union throughout was found. On the tenth day she began to walk about, and four days later walked home, apparently as well as ever. Up to this date she has so continued.

The tumor was ovoid in shape, four inches in length and seven in circumference where thickest. At either extremity a few nerve fibres and bloodvessels appeared to enter or take their exit. Otherwise there were neither adhesions nor pedicle. The growth was en-

capsulated with a tough brownish-colored membrane which brought away small granular portions of the tumor when forcibly separated from it by peeling. The neoplasm proper was of a yellowish-brown color, rather dry, and cut like fibro-fatty tissue. Exactly in the centre of the mass was a cavity, not definitely separated from the growth, which contained about half an ounce of bloody fluid. Most unfortunately, during the preparation of the specimen for further study, it was accidentally destroyed, so that I have not the satisfaction of adding to my clinical and gross pathological diagnosis of sarcoma that of microscopical confirmation. However, the details of several cases almost identical with this in every way, which I append, where sarcoma was proved by the only accurate method, will, I trust, be found to justify me in classing this case as one of that dread malady.

From the scant literature of peripheral nerve tumors I have abstracted the following cases, which are of great additional interest from the evidence which some of them afford relative to the remarkable regenerative powers of nerves, even when great lengths have been removed with tumors and suture has been omitted or found impossible.

Hume‡ reports the case of a man, aged twenty-four, who presented himself with a tumor on the back of the left thigh, which he had observed for five months. It extended from the fold of the buttock to the upper part of the ham, being ovoid in shape and movable from side to side, but not from above downward. There was much pain in the knee and foot, but no loss of motion or sensation. The tumor was easily shelled out with division of the entire nerve above and below. The growth was surrounded by and incorporated with the strands of the nerve. Besides the main portion of the tumor, the nerve trunk above and below appeared to be infiltrated with the same material, so that it was necessary to remove in all six inches of the sciatic. The cut surface of the growth was of a yellow fatty appearance. There were several hæmorrhagic spots in its substance; also others that looked like necrotic or caseating patches. It proved to be sarcoma. The man, soon after operation, was able to walk upon the limb, but there was much wasting and great impairment of sensation. Below the knee palsy of muscles and sensation was complete six months after operation.

A second case, recorded in the same place by Hume, was that of a man, thirty-seven, who had noticed a nodule under the gluteus maximus of the left side four months before coming under observation. He had been subject to molluscum fibrosum from childhood. At the time of operation the growth had attained the size of a "melon." It was found to originate in the great sciatic, the strands of the nerve being stretched over and incorporated with the capsule of the tumor. The small sciatic lay over the tumor and was pushed aside. To remove the growth it was necessary to entirely divide the nerve close to the sciatic notch above and at the border of the gluteus below. By stretching of the nerve ends and extreme flexion of the knee and extension of the hip, all of the upper end of the nerve and one-half of the lower extremity were brought to-

‡Lancet, September 19, 1891, p. 654.

gether and sutured with strong catgut. In order to lessen strain upon the sutures the patient was made to assume the prone posture with the hip in extreme extension. The tumor was found to be a round-celled sarcoma. There was primary complete paralysis of the functions of the sciatic. Eighteen months later skin sensibility of the foot was absent, but that above the ankle was about normal, and there was very little atrophy of the muscles. At this time he presented a large sarcoma of the right chest wall, with pleural effusion, and died five months subsequently. In was then found that he also had a growth in connection with the pleura; nodules in several of the intercostal nerves, the liver, and in the humerus and lung of the opposite side. At the site of the operation the sciatic nerve was found at the level of the tuberosity of the ischium to be divided into two portions; the internal of these passed into a nodular swelling which was continuous upward with the proximal portion of the nerve; the external portion was lost in cicatricial tissue, by which it was attached to the surrounding parts and to the side of the nodule. The whole thickness of the lower end of the central portion was continuous with the nodular swelling. The latter had evidently formed at the line of sature with that portion of the peripheral division of the nerve which it had been possible to bring into contact at the operation. The nodule consisted entirely of nerve tubules and fibrous tissue. There was no local recurrence of sarcoma.

Hume, in the same article, also records the following case: A man, aged forty, had recognized a rapidly growing nodule behind his knee for four months. Upon incision a large oval growth of great vascularity was found in connection with the internal popliteal nerve. The short saphenous nerve was stretched over it, thus explaining all pain that the patient had suffered. Three and a half inches of the nerve were excised. The ends were not sutured. The man soon returned to his occupation of miner, with paralysis of the popliteal distribution. The growth was encapsulated in the sheath of the nerve and appeared to be defined at each end, but a small number of nerve fibres passed through it. The bulk of the substance of the nerve laid behind the tumor. In its interior one or two cavites filled with blood were found. Six years subsequently the cutaneous sensibility of the leg had returned to the normal, excepting a slight impairment in the centre of the sole. and all muscular movements of the leg and toes were perfect. There was no wasting of the parts whatever.

Little§ reports the following case: A woman, aged twenty-five, presented a large, firm tumor upon the posterior portion of the thigh above the popliteal space. The first symptoms were dull pains along the thigh and upward. There was no pain in walking, but considerable discomfort in sitting. The tumor pedicle sprang from the sciatic nerve sheath. One inch of the nerve was resected and the ends sutured together. The functional result was almost perfect in a few months. The growth was twelve inches in circumference. It proved to be a sarcoma, and probably originated from the neuroglia. There was a true bony centre in the tumor.

§Boston Med. and Surg. Jour., Dec. 3, 1885, p. 533.

McBurney‖ records a case where a man, aged twenty-seven, presented a growth of six years development upon the inner side of the right arm. There had been no considerable pain until a month before operation; the pain extended down the arm, and pressure was exceedingly painful. It was found to spring from the median nerve in the upper third of the arm; was encapsulated, and, when opened, it was seen that the fibres of the nerve spread over the growth. The major portion of the tumor was behind the nerve. The neoplasm and capsule were removed with division of but a few fibres of the nerve which entered it. Microscopic examination proved the tumor to be fibro-sarcoma.

In addition to the above detailed cases I have been able to find the following references to sarcoma of nerve trunks:

Ramoneda: Sarcoma fuso-cellular del nervio neumo-gastrico derencho, su extirpacion, conservándose la continuidad del tronco nervioso; dotos intersandes acerca del nervio hipogloso. Rev. clin de l'hosp. Madrid, 1891, iii., p. 241.

Van Inschot: Fibro-sarcome caverneux du nerf radial (propage an triceps brachial). Ann. Soc. de med. de Gand., 1887, lxvi., p. 14.

Weile: Ein Fall von Sarcom. des Nervus radialis. Erlangen, 1888, 8vo.

Bardeleben: Sarcom des Nervus ischiadicus. Charite Ann., 1883, Berlin.

Herczel: Ueber Fibrome und Sarcome der peripheren Nerven. Beitr. zur path. Anat. u. z. alleg. Path. Jena, 1890, viii., p. 38.

Peret-Gilbert: Considerations sur les neoplasmes primitifs des nerfs des membres. Paris, 1891, 4to.

Krause: Ueber maligne Neurome und das Vorkomen von Nervenfasern in denselben. Samml. klin. Vort. 1887, No. 293.

‖New York Med. Jour. May 1, 1886, p. 504.

In the pursuance of the policy recently announced in the resolution to be presented to the American Medical College Association, the Trustees and Faculty of Rush Medical College have decided to require four years attendance at College for students who begin the study of medicine this year with a view to graduation in 1898; however, those who have already studied medicine one year or more with a preceptor, so that the four years of study already required will be completed before July, 1897, may graduate after three courses of lectures as heretofore. To encourage proper preliminary study, graduates in Arts and Sciences from high grade colleges, and graduates in pharmacy and dentistry from colleges requiring a proper amount of study and two full courses of lectures will, until further notice, be allowed to graduate after an attendance on only three courses of lectures."

For chronic constipation, Ewald recommends four or five grains of a combination of caffeine and chloral dissolved in water. The remedy is given by injection, and he states that he has failed only once in thirteen trials in obtaining thin stools.

To abort gonorrhœa, wash out anterior urethra for four days with 1 to 4,000 permanganate of potassium.—JAMIN.

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BALTIMORE, JANUARY 20, 1894.

Editorial.

THE OHIO MEDICAL BILL.

The medical profession of Ohio has agreed upon a medical bill which will be presented to the Legislature of that State during the present session. There is good prospect that the bill will become a law. The bill provides for the appointment by the Governor of a board of medical registration and examination, consisting of seven members.

On this board each of the different schools of medicine is to be given representation in proportion to its numerical strength in the State, but no one school is to have a majority of the whole board. The members are to be appointed for seven years, and shall organize by electing a president, secretary and treasurer. The secretary is to receive $1,500 per year, and the treasurer must give bond in the sum of $10,000. Members of the board are to receive $10 a day and expenses for time actually employed.

After the passage of the act, no one shall practise medicine, surgery or midwifery who has not obtained a certificate from the board. Graduates of medical colleges recognized by the board will be given a certificate on presentation of their diplomas, with proper authentication. Those not graduates, but who are under present laws legal practitioners, will be furnished with a certificate on giving to the board such evidence as may be required, and those who are not graduates or legal practitioners may be examined, and if the examination be satisfactory, certificates will be furnished.

Graduates and legal practitioners will be charged $5 for a certificate, and those undergoing examination will be required to pay $25, the fees to be paid to the treasurer of the board, and the expenses of the board are to be paid out of the fund so created. Certificates issued by the board, or certified copies of them, must be filed with the probate judge of the county in which the practitioner resides, and in case of removal of the practitioner he must obtain a certified copy of the certificate from the probate judge of the county in which he resided. Each probate judge is to report to the secretary of the board a list of all certificates filed with him.

Persons practising midwifery must, within ninety days after the passage of the bill, register with the probate judge of the county in which she resides, stating her name, age, length of time and places during, and at which she has been engaged in the practice of midwifery, paying to the judge a fee of $5 for such

registration. Of this fee the judge may retain fifty cents, and the balance he must transmit to the treasurer of the State board. Certificates are to be issued by the probate judge to each person so registering, and a list of all such registration is to be furnished, annually, to the secretary of the State board.

All persons who shall, after the passage of the bill, enter upon the practice of midwifery, must appear before the State board and be examined, paying a fee therefor of $10. The certificate issued to successful applicants must be filed with the probate judge, and a fee of 50 cents paid for such filing. Medical officers of the regular army, navy and marine corps, and legal practitioners of other States in actual consultation with legal practitioners of Ohio, are exempted from the provisions of the bill.

A penalty for unlawfully practising medicine is imposed, and is from $200 to $500, or imprisonment in jail from 30 days to one year, or both. Midwives unlawfully plying their vocation are subjected to a fine of from $25 to $100. One-third of all the fines goes to the informer, one-third to the poor fund of the county, and the balance to the State board.

Whilst this law differs in many respects from those now in force in other States, it will do much good for the profession of Ohio, and is far better than no law.

TYPHOID FEVER AND DRINKING WATER.

It is now universally admitted that the majority of cases of typhoid fever are from drinking water infected with the discharges from typhoid fever cases.

It is, therefore, theoretically as well as practically true that this disease is preventable. Many illustrations can be offered to show the influence of sanitation and of prophylactic measures upon the origin and spread of typhoid fever, both in large and small communities.

The fact that sanitation has reduced the percentage of cases of this disease in the larger communities, whilst it continues to exercise its influence in the small towns, villages and rural districts, where no supervision over springs, wells and water courses is had, is the strongest argument in support of the theory of water infection.

The cause of typhoid fever being admitted, statistics will throw much light upon the extent of the disease and the loss sustained through its agency. Figures are at times very impressive. They serve to show how items increase in magnitude by compilation.

Prof. V. C. Vaughan, of Ann Arbor, Mich., has offered much suggestive material bearing upon the annual loss to this country through this one preventable disease. He estimates that we have 50,000 deaths annually from typhoid fever. The average value of an adult life is worth to the State $1,000. The anunal loss from death at this estimate is $50,000,000. For every death from the disease at least ten others are sick with it. One half a million people are therefore sick every year. The average duration of sickness is twenty-eight days. The pecuniary loss from this source Prof. Vaughan places at $14,000,000, making a total loss in dollars to the Nation of $64,000,000, or about one dollar for every inhabitant.

But the financial loss makes no allowance for the sorrow and grief which come to the thousands of homes through this annual sickness and death. Prof. Vaughan asks, Why do we allow this preventable disease to prevail among us? No one can answer such an inquiry, but all will admit that much more consideration should be given to such questions than is now given. The medical profession could do very much more than it does to enlighten public opinion upon such subjects as the one here suggested.

This holds true especially among men who practise medicine in the towns and country places where well and spring water is in danger of being infected or has been infected.

MEDICAL CORPS OF THE UNITED STATES ARMY.

The Medical Corps of the Army presents a most inviting field of practice for the young surgeon. With a view of making the work and advantages of the army medical service better known, Dr. George M. Sternberg, Surgeon General, has recently issued a circular of information which we think of sufficient interest and importance to publish at some length. Dr. Sternberg says:

"The Medical Corps of the Army consists of a Surgeon General with rank of brigadier general, six Assistant Surgeons General with the rank of colonel, ten Deputy Surgeons General with the rank of lieutenant colonel, fifty Surgeons with the rank of major, and one hundred and twenty-five Assistant Surgeons with the rank of first lieutenant, mounted for the first five years, and the rank of captain, mounted, thereafter, until promoted to major. Promotion through the intermediate grades of rank from that of captain to that of colonel is by seniority, but there is an examination for the rank of captain, and another for that of major, to ascertain the fitness of the officer for promotion. Advancement to lieutenant colonel and colonel takes place without further examination. The Surgeon General is selected by the President from among the members of the corps. All vacancies are filled by appointment to the junior grade.

"To each rank is attached a fixed annual salary, which is received in monthly payments, and this is increased by ten per cent. for each period of five years' service until a maximum of forty per cent. is reached. An Assistant Surgeon with the rank of 1st lieutenant, mounted, receives $1,600 per annum, or $133.33 monthly. At the end of five years he is promoted to captain and receives $2,000 a year, which with the increase of ten per cent. for five years' service, is $2,200, or $185.33 per month. After ten years' service he receives $2,400, after fifteen years $2,600, and if he remains a captain after twenty years, $2,800 per year. The pay attached to the rank of major is $2,500 a year, which, with ten per cent. added for each five years' service, becomes $3,250 after fifteen years and $3,500 after twenty years. The monthly payment of lieutenant colonel, colonel, and brigadier general is $333.33, $375, and $458.33 respectively. Officers, in addition to their pay proper, are furnished with a liberal allowance of quarters according to rank, either in kind, or, where no suitable Government building is available, by commutation. When traveling on duty an officer re-

ceives four cents per mile and reimbursement of money actually expended for railroad or other fares. On change of station he is entitled to transportation for professional books and papers and a reasonable amount of baggage at Government expense. Mounted officers, including all officers of the Medical Corps, are provided with forage, stabling, and transportation for horses owned and actually kept by them, not exceeding two for all ranks below a brigadier. Groceries and other articles may be purchased from the Commissary and fuel from the Quartermaster's Department at about wholesale cost price. Books and instruments are supplied in abundance for the use of medical officers in the performance of their duties."

Medical Progress.

DIET IN TYPHOID FEVER.

Dr. W. F. Waugh (*Times and Register*) says:

The disease affecting the glandular apparatus of the intestines, absorption through this channel is impossible, and the patient can only be nourished by means of absorption through the veins.

That this is insufficient is shown by the cases occasionally seen of occlusion of the thoracic duct, in which the patient becomes greatly emaciated.

In fact, this condition is exactly paralleled in typhoid fever, where the glands drained by the thoracic duct are rendered incapable of absorbing food. The only exceptions to this rule lies in the facts that all of Peyer's glands may not be wholly disabled at the same time; as the glandular affection is somewhat progressive from above downwards and some of the glands may not be affected at all.

It becomes, then, a question whether we can supply food at all during a typhoid attack; whether any substance can be directly absorbed into the veins without passing through the intestinal glands and yet be assimilated.

There are two substances to which this may be possible. Egg albumen is directly absorbed into the tissues of the growing chick, without digestion or assimilation. The food is the life; the digested, assimilated and vitalized final product of the whole chain of processes by which food becomes transformed into an integral part of a living organism.

If any substances are available in these cases it must be these. Even milk must be digested before it goes to nourish the child.

Several years ago I presented this subject, and spoke of the excellent results I had obtained from the use of these foods in typhoid fever.

The white of egg can be mixed with iced water and given very readily.

For blood we must rely on bovinine, as fresh blood cannot possibly be obtained at the times it is required.

Bovinine, consisting of beeves' blood and egg albumen, preserved with glycerine and whisky, with a little foric acid, answers the need most admirably. It has been my reliance in feeding to typhoid cases for many years, and its success has demonstrated the correctness of the above propositions.

Fourteen drops to a teaspoonful may be given every two hours, day and night.

Patients fed on bovinine get up with much less emaciation than those fed on soups or undigested milk.

Quite recently a very remarkable series of cases have been reported, in which chronic ulcers, even of many years' duration, have been cured by the local application of bovinine. Several hundreds of such cases have been so treated with great success. These go so far to confirm my views; for if bovinine can be absorbed from the surface of an ulcer, or from the subcutaneous tissue about it, and so improve the local nutrition as to bring about healing, how much more likely that such a substance can be absorbed from the stomach, and keep up the general nutrition.

OPERATIVE TREATMENT OF TUBERCULAR KNEE-JOINT DISEASE.

De Forrest Willard, M. D. (*Univer. Med. Mag.*), divides operative treatment of tubercular knee-joint disease as follows:

I. Tenotomy with fixation.

II. Removal of serum.

III. Removal of pus accumulations and degenerated tissues inside and outside the joint.

a. Aspiration.

b. Incision and drainage.

c. Erasion.

d. Excision.

e. Amputation.

IV. Hypodermic injections of anti-bacillary substances, as iodoform, chloride of zinc, etc.

V. Removal of late deformity.

a. Tenotomy.

b. Forcible extension with tenotomy.

c. Osteotomy.

d. Partial or complete excision.

VI. Treatment of posterior displacement.

After discussing the various methods of treatment, he presents the following conclusions:

1. Mechanical treatment by rest, fixation and the use of crutches, either axillary, perineal, or ischiatic, is absolutely essential both before and after operation.

2. In children under 12 years of age conservative measures should be carried to the extreme, and all operative procedures should tend to non-interference of the epiphyseal line for as long a period as possible, in order to assist growth of the limb. In these young cases, therefore, tenotomy with subsequent fixation should be the primary procedure, to be followed by erasion when necessary, and by excision only when life is absolutely threatened.

3. From 12 to 15 years of age conservatism should still be the rule, although the dangers from a shortened limb subsequent to operation are not so serious after growth has been completed. In adults operative treatment should be early and more radical in character, erasion still being preferable to excision, except in very degenerated cases.

4. Amputation should be employed in children only as a "dernier resort;" in adults with extensive disease it is often a wise procedure.

5. The introduction of anti-bacillary substances, both extra- and intra-articular, offers hope of retardation in the growth of bacilli, but as yet the procedure is in the experimental stage.

6. After the subsidence of all inflammatory symptoms the late deformity should be overcome.

a. By tenotomy, with forcible replacement.

b. By excision; rarely by osteotomy.

INTUBATION.

It seems to me that a careful comparison must convince any fair-minded observer that the operation has merits, has its place, which can be determined by the good judgment in a given case. There can be no doubt that intubation was judiciously used both by inexperienced operators, which led to bad results, and on the other hand by enthusiasts, who, for the purpose of making money and statistics, would intubate a well man on the street, if permitted. As to the value of statistics in general in determining a subject of this kind I hold to the opinion of Furneux Jordon, the famous surgeon of Birmingham. He expresses himself as follows (*Surgical Enquiries*, p. 167): "Statistical enquiry in the inexact sciences has misled as often as it has led. There are more avenues for errors to creep into statistics than there are avenues for errors to creep into the opinions of trained observers. If six competent surgeons tell me one thing and the statistics of 600 hospitals tell me another, I believe the six surgeons."

Intubation has come to stay. There is no fair comparison of the "present revival" with any previous attempt in the same line. Bouchut's tubes in 1858 were like mere open end thimbles and their method of use correspondingly imperfect. He had the crude idea right but could not execute it. It was left for O'Dwyer's mechanical genius to work out perfection in the tubes, and so near perfection in the accessory instruments and methods of their use that, notwithstanding many attempts, very little if any improvement has been effected by newer modifications. Casselberry's plan of lowering the head of patient to feed is as good a thing as has been added to the original plan. Waxham has a gag with a different catch, and so on. Some operators wear a ring on the forefinger, some a piece of adhesive plaster across the back of the finger, but these differences are of no moment. Some children hold the mouth open voluntarily. The fact that an anæsthetic is seldom required is a point in favor of intubation. Thorough cleanliness and antiseptic principles should be carefully observed in the practice of intubation. The use of the same tubes and other throat instruments indiscriminately in diphtheritic or syphilitic and in non-contagious cases is especially reprehensible. Another abuse is the cessation of medical treatment when the tube is placed in the throat. Because the mechanical obstruction to respiration has been mechanically relieved for the time being, is no reason why we should cease administering drugs directed against the pathological condition. One should continue the treatment by way of the stomach, by local applications, by lime steam. Sometimes too much reliance is placed upon the operative aid, and the disease, baffled temporarily, renews the attack in another quarter and the patient finally succumbs.

In conclusion, I would reiterate my belief that intubation has come to stay. It will be permanently recognized by the profession as one of the standard life-saving operations. The more one studies it and practises it the more he must admire the ingenuity, the pa-

tience and the thoroughness with which O'Dwyer worked it out. It will not supplant tracheotomy. Each operation has its field of usefulness; each its rational and recognizable indications.

TEUCRIN IN LOCAL TUBERCULOSIS.

The December number of *Les Nouveaux remèdes* refers again to the efficiency of teucrin as a remedy in the treatment of local tubercular affections. Mosetig-Moorhof, according to the *Wiener medicinische Presse*, has been giving the drug a fair trial and is highly satisfied with the results. The medicament is used subcutaneously at the base of the degenerated tissue, and cures by causing sloughing of the tubercular parts. Great judgment must be exercised, it is said, both as to the quantity of the drug used and as to the number of applications; one is to be guided entirely by the slowness or rapidity of its action. The author has never seen any systemic reaction to the drug exhibited, and thinks that, employed with care, it is a very safe and sure remedy for the extirpation of local tuberculous disease.—*New York Med. Jour.*

SHOULD THE PRACTITIONER SUPPLY HIS OWN MEDICINE?

In reply to this query it must be said that, in the present state of medical affairs, as a general rule, in a vicinity amply supplied with competent pharmacists, the practitioner has no right to compound or to carry drugs to dispense with his own hand to the patient.

Holy Writ says that "the laborer is worthy of his hire." And so is the trained, qualified pharmacist. Pharmacy and medical practice, while a close affinity subsists between them, are separate and independent branches of the healing art.

The physician in a large city who carries and dispenses medicines, by that act loses caste; he does an injustice to his patient, and appropriates to himself what justly belongs to the druggist, who depends largely on prescriptions for his support.

It is alleged that the physician saves the patient the expense of prescriptions and so retains him. But the fact is he fails in both. In very many cases he might as well dose his patients with fragments of chips, pebbles or other inert substances as to give him the stale, petrified tablets, which, with time, have lost their potency. His patient has no respect for the preacher-practitioner combination, nor has he any enduring faith in the walking apothecary shop, hence when he is really seriously ill he will pay only for the straight article.

"Let the shoemaker stick to his last" is an old and true saying. If we would stop counter-prescribing, the pharmaceutical treatment of gonorrhœa and amenorrhœal (?) troubles, then we must give to the honest pharmacist what justly belongs to him. Pharmacists as a class are appreciative, and no physician ever patronized one and was not repaid twofold. What we have said does not apply to the country practitioner, nor to the use of emergency drugs for night practice.—*Medical and Surgical Reporter.*

THE PARTURIENT WOMAN'S BED.

The following advice is given in the *Amer. Gyn. Jour.:* Commence with a good, firm mattress; eschew feathers. Cover the mattress, if you please, with a rubber sheet and over it spread the cloth

sheet. Have the patient wear, in lieu of a night-gown, a short sack scarcely reaching the hips. After she takes her bed, place under her hips a pad of absorbent cotton covered with cheese cloth, about thirty inches square and one inch thick. Place a similar pad, folded, under the small of the back and resting upon the upper margin of the first pad. The pad under the hips will absorb all the fluids incident to labor, while the one under the back will prevent fluid creeping up to the patient's shoulders. After labor, withdraw the pads. With them will come all fluids, and the patient, with no annoyance or trouble, finds herself in a clean and dry bed. Now place a pad eighteen inches square under the hips and one two inches in diameter and seven or eight inches long against the vulva, to absorb subsequent discharges. Burn the soiled pads; they are cheap. Pads or accouchement sheets can be purchased ready made, as can the vulvar pads. The vulvar pads should be changed as soon as they become soiled. The large pad placed under the hips after delivery can remain from twelve to twenty-four hours, after which time the vulvar pads will be sufficient to absorb all discharge.—*Med. Brief.*

HOW TO BECOME A "PROFESSOR."

As this seems, at the present day, to be one of the prime objects of our fraternity, some valuable hints on the subject may be culled from some remarks of Dr. Jacobi, at the annual dinner of the Harvard Medical Alumni Association, given in a recent number of the *Western Medical Reporter*. Dr. Jacobi said:

"There are many ways of becoming professors, some of which are as follows: Thirty years ago I was offered the place of professor of diseases of children. I replied I could not think of accepting; I did not know enough. My friend, who was a professor and knew all about it, laughed and replied if he were offered a chair of nautics he would begin lecturing to-morrow. That is, gentleman, how I became professor of pediatrics, only because there was no place vacant for a Columbus. Others are cousins, friends, assistants in private practice. To be rich, well connected, and have relatives among hospital and college trustees is a very good mental equipment. Have a friend who is wealthy and endows a chair for you. In Germany, be a son-in-law of a leading professor. But lately I read of the death of a German *Privatdocent*, at the ripe age of seventy-four, whom I knew when he was already *Privatdocent*, but proved his incapacity for advancement by refusing to marry the daughter of the full chair. Write a text-book while you are young and fresh. There are so many that you can extract half a dozen, and make the seventh with the aid of very little brains and much more posteriora. Operate on two alleged lacerations daily, and let no more than fifty per cent. die of septicæmia. Prove that the best place for ovaries is in a jar. Render yourself a parody of the great Philadelphian who makes a diagnosis before he cuts babies' skulls, by sawing without diagnosis. The first is seen and heard and heard of; the latter is not. On that line there are many possibilities."

REMOVAL OF SUPERFLUOUS HAIRS.

In a paper read before the recent meeting of the American Dermatologi-

cal Society, Dr. R. B. Morison, of this city, states that he has given up the use of electrolysis in the removal of superfluous hairs. The results which he had had himself, and those which he had seen of others, have not been sufficiently good to warrant its continuance. He finds that the proper application of a good depilatory answers the purpose much better. There are many women who wish to get rid of the white lanugo down on their faces, upon whom it seems that electricity cannot be used for fear of stimulating the growth of the surrounding hair, and the appearance of permanent scars. If a preparation of yellow sulphate of arsenic and quicklime, of equal parts, made into a paste with hot water, be allowed to dry on the hairy skin, it removes the hair for ten to twenty days, and sometimes permanently. On the other hand, nothing seems to take the place of electrolysis where there are a few strong hairs growing from moles, in the removal of moles themselves, in angioma, or in permanent small, red spots.

CLINICAL ASPECTS OF FIBROID PHTHISIS.

In an article on the varieties of pulmonary tuberculosis, by Dr. J. K. Fowler, published in the *Practitioner*, this author gives the following *resume* of fibroid tuberculosis: 1. Men are more often affected than women, and the period of onset is later than with the ordinary type. 2. The tendency to fibrosis is increased in those individuals whose lungs have been rendered vulnerable by inhaling irritating dust particles; the affection is therefore common among workers in various trades, *e. g.*, miners, knife-grinders, etc.; but it is by no means confined to such subjects. 3. There is often no family history of tuberculosis, but in one of the most marked examples known to the writer, several brothers had suffered from tuberculous disease. 4. It is often accompanied by hæmoptysis, which may be profuse and recurrent. After the early attacks of hæmoptysis there may be no physical signs of disease within the lungs—their absence is of course no proof that such is the case. 5. Emphysema and bronchial asthma are frequently found in association with it. Catarrh may be present, but in some cases there is not the slightest tendency to that condition. 6. It is characterized by apyrexia which may persist almost throughout the case, even during periods of extension of the disease within the lungs. 7. The cough has not the paroxysmal character observed in "fibroid phthisis," and does not tend to produce vomiting. 8. There is an absence of night sweats, and, generally speaking, of all acute symptoms. Dyspnœa is proportionate to the extent of infiltration and of emphysema, if present. 9. The sputa may be free from bacilli, or on the other hand they may always be present when looked for, a condition which is quite consistent with an absence of signs or symptoms of progressive disease. In a case known to the author they have been invariably found, when searched for, since the year 1882, during which period the individual has enjoyed almost uninterrupted good health. Microscopical examination of fibroid lesions in a stage of arrest may fail to show the presence of bacilli; although to the naked eye the appearances are unmistakably tuberculous. 10. The physical signs may consist of weak

breath sounds and fine crackling rales mixed with catarrh sounds. The rales may be widely distributed, but tend to spread from the apex toward the base. There may be no dulness; in its place there is often hyper-resonance from emphysema. 11. The wide area of the lungs over which the physical signs are present, in advanced cases, is often in marked contrast with the apparent well-being of the individual. 12. Fibroid tuberculosis tends more than any other form of the disease to undergo arrest, and, short of that, to run a very prolonged course. Its recognition, therefore, becomes of great importance from the point of view of prognosis.—*Med. Rec.*.

Medical Items.

The number of women in the Medical Department of the Michigan University is larger than ever, as also in the Literary Department.

Dr. James E. Reeves, of Chattanooga, Tenn., will shortly issue a book on Medical Microscopy for the use of medical students and general practitioners.

The Medical Society of the State of New York will hold its eighty-eighth annual meeting in the City Hall, at Albany, on Tuesday, Wednesday, and Thursday, February 6, 7, and 8, 1894.

One of the latest registers gives the number of physicians in Ohio as 7,554; Indiana, 5,006; Kentucky, 4,063; West Virginia, 1,061; of whom not less than 14,000 are regular physicians in active practice.

The Board of Regents of the University of Minnesota have extended the course of study in the Medical College from three to four years of eight and one-half months each course. The new rule becomes operative in 1895.

The Philadelphia Academy of Surgery elects its officers triennially. At the meeting held January 8th, Dr. Wm. Hunt was chosen President; Dr. W. W. Keen, Vice-President; Dr. Thomas R. Neilson, Secretary; and Dr. William G. Porter, Treasurer.

Dr. E. J. Tilt, a well known English physician and author, died on Dec. 17th, from cerebral hæmorrhage. Dr. Tilt was well known in this country as the author of an instructive book entitled "The Change of Life." He was also the author of a work on "Uterine Therapeutics."

The Medico-Chirurgical College of Philadelphia will create new Clinical Professorships of Otology, Genito-Urinary Diseases and Orthopedic Surgery. These professorships will be filled at an early date. The Faculty is also considering the question of a change to the four years' course.

Dr. S. Weir Mitchell, of Philadelphia, so well-known in the walks of science, medicine and general literature, gave two lectures in this city, during the present week. One on Wednesday evening at the Hopkins University on a literary subject, and one on Thursday afternoon at the Hopkins Hospital, on "The Use and Abuse of Rest in the Treatment of Disease."

Both of these lectures were largely attended and highly appreciated.

At a meeting of the Faculty of Jefferson Medical College, held on January 8,

1894, it was unanimously resolved to institute a compulsory four years' course with the session of 1895-96. This step was taken in order that the large clinical service of the Jefferson College Hospital (350 cases a day) might be utilized to the fullest extent in carrying out the desire of the Faculty to provide advanced medical education of a practical character.

Dr. W.J. Jones, one of the best known of the younger members of the profession in this city, died suddenly on January 10th at the age of 37. Dr. Jones was a graduate of the University of Maryland, class of 1883. He held a number of positions in the different medical institutions of the city, and was regarded as an energetic and careful worker. He was a man of most courteous and genial manners, and was much beloved by those who enjoyed his friendship.

It is proposed that the Association of American Medical Colleges adopt a rule enforcing a four years' course upon all medical students who intend to graduate in 1899 or subsequent years. The Association now embraces seventy-one colleges, and if this rule is adopted it will at once work a great change in the value of medical instruction given in America. We trust that the Association will see its way clear to adopt the new regulation.—*Med. Rec.*

The Martha Battey Hospital is an institution incorporated under the laws of Georgia and managed by a board of trustees. The buildings and grounds are the gift of Dr. Battey, in grateful recognition of the valuable aid his wife has rendered him in his surgical work at Rome. It is not designed to pauperize the people on the one hand, nor to beg contributitions from the charitable, but to offer comfortable shelter and necessary food and nursing at the lowest cost to patients and their friends, thus preserving their self-respect. Dr. Henry H. Battey is the surgeon in charge, and Dr. Robert Battey consulting surgeon. —*Med. Rec.*

Dr. Walter B. Platt, a well known and highly respected surgeon of this city, met with the misfortune of cutting his finger while operating upon a septic patient a few days ago. Though precautionary measures were taken, the wound became infected and Dr. Platt has been dangerously ill from blood-poisoning. At this time of writing we are glad to report an improvement in his condition. He has the sympathy of his professional friends in the misfortune which has befallen him.

An especially sad example of the dangers to which physicians are exposed is reported from Presburg, in Hungary. A physician, after visiting a patient with diphtheria, went home to change his clothes before continuing his calls. On entering the house his little son rushed up to him, and before the father could prevent it, had jumped upon him and kissed his face. Two days later the child was taken ill, and soon died of septic diphtheria. The father's reason gave way under the blow, and he died after a short illness, attended by acute delirium, in which he constantly cried out, "I have killed my boy."—*N. Y. Med. Rec.*

Chicago may be considered pre-eminently the city of typhoid fever. From January 1, 1890, to November 1, 1893,

there have been 5,087 deaths from this disease, or an average of 110 per month. This means that there have been from 25,000 to 30,000 cases. The epidemic began in 1889, with 453 deaths. The mortality increased until 1891 and 1892, when it reached nearly 2,000. It declined slightly in 1892, and has been somewhat less this year, but it is still very prevalent, there having been 712 deaths, and presumably over 4,000 cases, during the year ending September 30, 1893.—*N. Y. Med. Record.*

Over two hundred thousand persons have been vaccinated for nothing by the City Board of Health during the past year. Many of those vaccinated were able to pay, and some criticism has been aroused by the extensive and gratuitous labors of the Board. To this it may be answered that the city has a right to protect itself against small-pox as well as yellow fever or cholera. It might, however, in many cases accomplish the result by compelling vaccination by the family physician. Still, we suppose that if the people were to vote to establish State physicians who should treat everyone for nothing, it would be within the people's rights. But it would not be wise.—*Med. Rec.*

Dr. Paul Gibier read a paper "On a New Agent in the Treatment of Epilepsy," before the New York County Medical Society, on December 25. The material used was the nervous substance of the sheep, great care being exercised in securing absolute purity in the matter employed. He cited nine cases in which there were beneficial results and in four of these there were positive cures. "To sum up my results," he said, "in the treatment of epilepsy by injections of extract of nervous substance, I shall conclude by repeating, as in my first communication, that this method is especially beneficial in adding to the favorable effects derivable from other therapeutic agents, and by its application in the majority of instances the improvement is most satisfactory."—*Jour. Amer. Med. Asso.*

An Army Medical Board will be in session at Washington City, D. C., during April, 1894, for the examination of candidates for appointment to the Medical Corps of the United States Army, to fill existing vacancies. Persons desiring to present themselves for examination by the Board will make application to the Secretary of War, before March 15, 1894, for the necessarry invitation, giving the date and place of birth, the place and State of permanent residence, the fact of American citizenship, the name of the medical college from which they were graduated, and a record of service in hospital, if any, from the authorities thereof. The application should be accompanied by certificates based on personal acquaintance, from at least two reputable persons, as to his citizenship, character, and habits. The candidate must be between 22 and 28 years of age, and a graduate from a regular medical college, as evidence of which his diploma must be submitted to the Board. Successful candidates at the coming examination will be given a course of instruction at the next session of the Army Medical School, beginning in November, 1894. Further information regarding the examinations may be obtained by addressing the Surgeon General, U. S. Army, Washington, D. C., Geo. M. Sternberg.

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Original Articles.

PSYCHICAL EPILEPSY.*

BY S. J. FORT, M. D.,
OF ELLICOTT CITY, MD.

The curious relationship of the convulsive diseases, the faint boundary lines between what may be termed a well-marked disease, and another equally as well-marked; the combination of two disordered conditions in the one person, the peculiar features of Jacksonian epilepsy; petit mal in one patient, haut mal in another, and both forms in another, irregularities of symptomatology occurring among groups of accurately diagnosed forms of disease; all such eccentricities of diseased action render this group of diseases extremely interesting to the physiologist, the pathologist and the medical man proper, as well as to the medico-legal functionary.

The etiology in so many cases is obscure; the lesions, if any, would seem to be of a nature to produce contrary symptoms; very frequently the scalpel and the microscope fail to find sufficient pathological reason for marked pathological results. Cases operating from without produce directly opposite results in individuals apparently of the same physical equality.

A blow upon the knee of one child produces no injury beyond the subsequent bruise, in another child a destruction inflammation is lighted up and the joint is wrecked. One child falls and strikes its head, traumatic epilepsy ensues; others endure the same injury

*Read before the Semi-Annual Meeting of the Medical and Chirurgical Faculty, Nov. 22, 1893.

with no permanent injury resulting. A bruise in one woman's breast produces a cancerous growth on the site of the injury; other women recover from deep-seated trouble in these glands without an after-result.

One child is delivered by forceps and lives to be an idiot, hundreds of others show no signs of such manipulation at the time of their birth.

Notable examples of pre-natal impression and accidents are found among the institutions devoted to the care of the feeble-minded; among the many thousands who are annually born into the world, how many there may be who have been subjected to the most severe pre-natal shocks without injury, either mental or physical.

We study the tabulated family history of our defective charges and gravely point out the terrible ruin of a mind made by alcoholism in one or both parents; a similar study of family histories of thousands of parents addicted to alcoholism would show thousands of children born with minds to all intents and purposes sound and whole.

It may be that nature works without design in these troubles, that eccentricity of action argues a departure from rule in the primary cause of disease, but it is probable that the increased knowledge and further improved methods of study and research will eventually show the physical deficiency, if that be the reason; however infinitesimal it may be, it cannot forever elude the researches of modern science.

Of interest to the political economist as well as the medical man is the close relationship of the convulsive habit to crime and criminals, especially interesting since the latest crop of perverts whose mental and moral obliquity turn towards the destruction of human life. That this relationship exists is without doubt within the bounds of possibility. A somewhat intimate acquaintance with mental defectives has caused me to think that there is a far more intimate connection between the habitually vicious and depraved and the epileptic condition than at present insisted upon by authorities in this specialty.

The late Dr. Kerlin, whose thirty years of intelligent study of imbecility renders his writings of great value, in a paper published in 1881, describes what he terms the epileptic change in feeble-minded children, and the following case is one he presents which will sufficiently illustrate the remainder of his valuable paper.

A girl of four, when brought under observation, had a choreic habit of biting, but no other special eccentricity. During the fourteen years of training at Elwyn she ranked high in her school duties and became useful in household duties, but never really gave up her habit of biting; her paroxysms were always unannounced by visible prodroma; they were directed against the loved and unloved, and she was as irresponsible and helpless when snapping at her victim as the typical epileptic when he falls to the ground; her face became flushed after the act, with a wild, lost look in it, or sometimes it was as the face of a swimmer rising from the water more chilly than was anticipated when plunging into it—cold, cramped and surprised.

There were long suspensions of these attacks, like the hopeful rests of epilepsy, to be followed, like them, with disappoint-

ment, in a fresh outbreak of her irresponsible ferocities.

It would seem that the above case was that of what is now known as "psychical epilepsy," or the "psychical epileptic equivalent." Dana, one of the latest writers, thus describes psychical epilepsy, a sub-division of petit mal, or, to more accurately place it in its proper category, a sub-symptom of the mild form.

"Sometimes," says this author, "the minor attacks are followed by outbursts of maniacal excitement or by sudden violent automatic movements, and in these states, the patient commits crimes of violence. This form of epilepsy may come on without a preliminary minor attack, and then it is to be considered a psychical epileptic equivalent.

As I have said, I think that such a case as Kerlin describes would fall rather under this type of epilepsy, evidently identical with the "masked epilepsy" of Esquirol, the epilepsia larvata of Morel, rather than to be given as the prodroma of true epilepsy proper, and I place the two following cases of my own in the same class.

The first is a girl now 18 years of age, who came under mycare five years ago. She was then a dull, stupid imbecile, utterly unused to the requirements of polite society, unclean in her habits, irresponsive to either love or fear, but with no especial history of outbreaks of violence or destructive habits. Under the softening influence of our school training, she gradually brightened, began to talk, learned to read and write and displayed much affection towards her teacher and attendant.

One day she suddenly attacked her attendant, giving as an excuse that the attendant struck her first. When I saw her shortly after the fracas, she was a picture of sullen imbecility. Simultaneously with the explosion of muscular and nervous action, she seemed to have relapsed in the mental state of a year previous. In a week's time, she was herself again, and remained so for a month or two, when she again exploded. Isolated for a time from her companions, she regained her equilibrium and was removed from our care to her house.

As soon as she got home, she had recurring fits of passion, alternating with periods of sexual excitement, finally going to bed and refusing to get up. By use of much physical force she was brought back to us, and the morning after her arrival she rose with the other patients, but seemed in a trance, refusing to talk, eating voraciously, leading an oyster-like existence.

Under active treatment she finally regained her lost ground, but with her increased mentality came again the violent outbreaks of temper, followed by periods of depression. At no time in her history has there been any actual epileptic "fit."

Her family history is very bad. Her father is probably nothing more, mentally, than a high-grade imbecile; her mother was an illiterate, excitable person with an overgrown faculty for making money, who died recently of apoplexy, superinduced by over-eating.

The other case is a boy nearly 20. He has been under observation for three years. A nice, polite, clean fellow, capable of a certain amount of school education, fond of play, obliging and friendly. There was nothing in his history out

of the ordinary run of congenital imbeciles. Both parents highly cultivated, and, so far as known, no evidence of mental trouble anywhere on either side. The father lost a foot in battle, and has suffered intense neuralgia from the stump, the acme of pain-storms seeming to have been about the time the boy's mother became pregnant; this was the only symptom of nerve trouble anywhere in the history.

The boy showed signs of "backwardness" at an early age, and when about 14, without warning, eloped from home; he was returned by the police to a family well-nigh distracted and further alarmed by his being apparently insensible. He recovered in a short time, and within two months ran away again; this time he was found unconscious under a tree in a park near the house. Coming to me he become one of my most interesting cases, eager to learn, easily controlled and apparently trustworthy, giving no signs of any desire to elope for some time.

Looking out of a back window one afternoon during a heavy shower, to my surprise I saw this boy scudding across the field towards the woods. Immediate pursuit enabled us to corner him before he had gone very far, and he was finally located by a sort of barking noise and evidences were plain that he had vomited freely. Brought home, he was apparently unconscious, but when threatened with a douche of cold water, rallied and, beyond considerrble depression, in a day or two he was himself again.

Later on he again ran away, this time not being captured until late in the evening; he was thoroughly exhausted by his efforts at pedestrianisin and kept his bed for a week.

That was the last time he ever essayed that eccentricity; later he developed a new phase. He was brought to me suffering from a pain which he could not locate, and being sent to bed remained there two days, refusing to speak or eat. On the morning of the third day he got up with the other boys in his dormitory, dressed and took his place in his class as though he had never been away.

Gradually we noticed that he was standing still mentally; the slightest rebuff or reproof or obstacle to his desires brought on a paroxysm of this alleged and exceedingly elusive pain, to be followed by a period of depression, refusal of food and a most singular and marked physical change. He would begin the outbreak a fairly well-nourished boy, and in course of a few hours would look as though he had passed through a serious illness: his cheeks and eyes sunken, his features drawn, respiration, temperature and pulse below the normal. Equally remarkable is the rapid recovery of lost ground when reaction once sets in.

The female is essentially vicious and the boy needs only suggestion to become so; the moral sense is lacking in both and it is only the force of example and environment that prevents either from joining the ranks of juvenile criminals.

It may be wrong to argue that a possible inherent tendency to spasm may produce a crime as a result, rather than a fit, or that the relationship is so close that the criminal has a fit at one time, and at another the crime is substituted for the nervous explosion. "Human character," says Wood, "is the result of the established balance between the will and the intellectual attributes and the

emotional forces of the individual. When any of the correlated factors are altered there must be a corresponding change in character."

Close association with epileptics shows with great distinctness the result of this disturbance of correlated factors. The loss of will, the loss of memory, the lack of ability to inhibit the lower intellectual and emotional brain functions, the development of the passions, the growth of a superficial veneer of good behavior over the thoughts and desires of a satyr or bacchanal, kept in suppression only by the fear of a superior strength, the brutal, selfish, malevolent, surly, irascible, perverse egotism of epileptics is well known, especially in epileptic imbeciles. The Mr. Hyde of human nature is always in the ascendancy, and we find these same characteristics in numbers of criminals, particularly in the younger males and females who throng our courts and fill our station houses.

We have found out that the juvenile insane show a marked criminal tendency; we know that there is a distinct type of imbecile with the same tendency, which we call the moral imbecile, and I fancy, when each State will assume the burden of care and restraint of her epileptic defectives, that intelligent study will show that this terrible disease drives many of its victims to the penitentiaries, even to the gallows, for hideous crimes against the person, murder, arson, et al.

Proper education of the more juvenile delinquents would probably detect signs of what we have termed psychical epilepsy, and proper treatment eradicate the symptoms or point out the propriety of life restraint.

THE RELATION OF PELVIC DISEASE AND PSYCHICAL DISTURBANCES IN WOMEN. SOME FURTHER OBSERVATIONS AND RESULTS.*

BY GEORGE H. ROHÉ, M. D.,
Superintendent Maryland Hospital for the Insane.

In this report for 1892, I give the detailed history of eighteen cases of insanity in women, in whom the uterine appendages were removed for ovarian, tubal or other pelvic disease. Since that report, four additional cases were operated upon. Following are given a summary of the cases, together with the results in each case, to December 1, 1893.

A review of the case will show that even in apparently the most hopeless cases, a beneficial effect upon the mental functions is obtained by the removal of a persistent source of local irritation. Thus in one case of hystero epilepsy with violent maniacal attacks, lasting over eight years, complete recovery was obtained.

In four cases of puerperal insanity, two of over five years standing, three recoveries followed the operation, and the remaining case was greatly improved.

Three cases of profound melancholia recovered sufficiently to be discharged from the hospital.

In nearly every case operated on decided physical and mental improvement were noted.

While no claim is made that gynecological operations are generally indicated in insane women, it is held that where insufficient disease exists to demand treatment on its own account, the mental disturbance of the patient should be

*Advance sheets from the Ninety-sixth Annual Report of the Maryland Hospital for the Insane, 1893.

an additional reason for early and effective interference.

In the present conservative tendency among gynecologists, there is danger of delaying radical measures too long. If this delay is injudicious in the sane, as I firmly believe it to be, it is no less in the insane, where recovery of mental health may be retarded or rendered impossible, by hesitancy or neglect.

I have been subjected to criticism, some of a rather savage character, for my work in this line. Some of my critics know, confessedly, little of the great advances made by modern gynecology, while others were no loss ignorant of the results of recent studies of mental pathology. I have refrained from replying to these criticisms because I could afford to await results. The facts here presented will, I am sure, be regarded by all unprejudiced minds as sufficient answer to the criticisms upon my course.

Case 1, admitted Dec. 19, 1886; duration of insanity at time of admission, second attack, ten weeks. Age 33, married; puerperal mania; lacerated cervix, ruptured perineum, adherent ovaries. Operation Oct. 6, 1891: removal of uterine appendages, restoration of perineum, trachelorrhaphy. Decided mental and physical improvement. Recently phthisis developed, under which she is rapidly losing ground.

Case 2, admitted May 21, 1891; duration of insanity at time of admission, four months. Age 32, married; melancholia; lacerated cervix. Operation Oct. 13, 1891: removal of the uterine appendages. Physical improvement, no mental change.

Case 3, admitted Feb. 26, 1890; duration of insanity at time of admission, three months. Age 39, single, hysterical mania; anteflexio uteri, firm adhesion of right ovary and tube. Operation Oct. 21, 1891: removal of the uterine appendages. Decided physical improvement, no noticeable mental change.

Case 4, admitted Mar. 2, 1891; duration of insanity at time of admission, three months. Age 31, single; melancholia; enlarged ovaries. Operation Nov. 4, 1891: removal of the uterine appendages. Decided physical and mental improvement, patient at home nine months; nearly well.

Case 5, Oct. 5, 1891; duration of insanity at time of admission, one week. Age 30, married; melancholia; cystic and adherent ovaries. Operation Nov. 4, 1891: removal of the uterine appendages. Physical and mental improvement. Patient discharged from the hospital Oct. 1, 1893. Four weeks later she was run over by a railroad train; this may have been a case of suicide, but there is no evidence of this.

Case 6, admitted Oct. 12, 1891; duration of insanity at time of admission, one year. Age 29, single; simple mania; retroversio uteri, adherent ovaries. Operation Nov. 19, 1891: removal of the uterine appendages. Physical improvement. Slight mental improvement.

Case 7, admitted May 16, 1890; duration of insanity at time of admission, second attack, three days. Age 37, married; puerperal mania; lacerated cervix, adherent ovaries. Operation Nov. 25, 1891: removal of the uterine appendages. Physical improvement. Mental recovery. Discharged recovered Aug. 21, 1892. Remains well Dec. 1, 1893.

Case 8, admitted Mar. 30, 1885; duration of insanity at time of admission, unknown. Age 23, married; hystero-epilepsy with mania; cystic ovaries Operation Dec. 10, 1891: removal of the uterine appendages. Discharged entirely recovered May 12, 1892. June 30, 1893, she had two hysterical attacks, following accidental death of a relative. She was kept under observation three weeks without any return of the attack. Dec. 1, 1893, she remains entirely well.

Case 9, admitted Aug. 23, 1887; duration of insanity at time of admission, four months. Age 39, married; puerperal mania; lacerated cervix, adherent ovaries. Operation Dec. 15, 1891: removal of the uterine appendages. Great physical and mental improvement. Pa tient from being one of the worst and most troublesome in the hospital improved so much that she could be discharged from the hospital Nov. 28, 1893.

Case 10, admitted Apr. 4, 1890; duration of insanity at time of admission, epilepsy, ten years. Age 25, single; epileptic insanity; ligamentary cyst size of orange. Operation Dec. 30, 1891: removal of ligamentary cyst and uterine appendages. Died in status epilepticus. Probably septicæmia.

Case 11, admitted Oct. 22, 1888; duration of insanity at time of admission, three months. Age 24, single; melancholia; cystic ovaries, and congested and tortuous tubes. Operation Jan. 19, 1892; removal of the uterine appendages. No mental change.

Case 12, admitted July 11, 1891; duration of insanity at time of admission, epilepsy, seven years. Age 23, single; epileptic insanity; double pyosalpinx and ovarian abscesses. Operation Feb. 9, 1892: removal of the uterine appendages. Died of septicæmia.

Case 13, admitted Dec. 28, 1891; duration of insanity at time of admission, third attack, three days. Age 28, married; puerperal mania, ruptured perineum, enlarged and prolapsed ovaries. Operation Mar. 9, 1892: removal of the uterine appendages. Discharged entirely recovered May 8, 1892. Dec. 1, 1893, remains well.

Case 14, admitted Feb. 22, 1892; duration of insanity at time of admission, ten months. Age 43, single; melancholia; cirrhotic ovaries. Operation Apr. 20, 1892: removal of the uterine appendages. Decided physical and mental improvement.

Case 15, admitted Apr. 12, 1892; duration of insanity at time of admission, epilepsy, nine years. Age 24, single; epileptic insanity; cystic ovaries. Operation May 12, 1892: removal of the uterine appendages. Convulsions less frequent but still persist, slight mental improvement.

Case 16, admitted Oct. 31, 1882; duration of insanity at time of admission, two years. Age 30, single; periodic mania; cystic ovaries. Operation July 14, 1892: removal of the uterine appendages. Very decided mental improvement.

Case 17, admitted May 14, 1892; duration of insanity at time of admission, two years. Age 29, widow; paranoia; cystic ovaries; trachelorrhaphy had been done for lacerated cervix. Operation August 30, 1892: removal of the uterine appendages. Improved considerably, but was removed from hospital, and is now reported worse.

Case 18, admitted June 7, 1892; duration of insanity at time of admission, five years. Age 30, married; periodic mania; lacerated cervix, retroflexio uteri, cystic ovaries. Operation Sept. 12, 1892: removal of the uterine appendages. Decided mental improvement, which continues.

Case 19, admitted Sept. 12, 1892; duration of insanity at time of admission, two years. Age 30, single; hysterical mania; retroverted and adherent uterus, cystic ovaries. Operation Dec. 1, 1892: removal of the uterine appendages. No mental change.

Case 20, admitted Nov. 3, 1892; duration of insanity at time of admission, two years. Age 23, married; melancholia; retroversio uteri, lacerated cervix, cystic ovaries. Operation Jan. 19, 1893: removal of the uterine appendages. Complete physical and mental recovery. Discharged Apr. 1, 1893. Remains well Dec. 1, 1893.

Case 21, admitted June 11, 1891; duration of insanity at time of admission, one year. Age 17, single; periodic mania; enlarged ovaries and tortuous tubes. Operation Feb. 2, 1893; removal of the uterine appendages. Decided progressive mental improvement.

Case 22, admitted May 26, 1893; duration of insanity at time of admission, five years. Age 40, married; hystero epilepsy with mania; firmly adherent ovary on right side. Ovary and tube of left side absent. Ventral hernia from a previous abdominal section. Operation Oct. 26, 1893: removal of ovary and tube on right side. Operation too recent to give ultimate result.

THE HYPODERMIC INJECTION OF MAGNESIUM AS A PURGATIVE.*

BY J. PERCY WADE, M. D.,

Assistant Physician, Maryland Hospital for the Insane.

In 1873, M. Luton made the statement† that ten centigrammes of sulphate of magnesium, injected under the skin, regularly produced purgation. Claude Bernard had previously stated that when injected into the vein, Epsom salts produced a purgative effect.

These statements appear to have attracted very little attention on the part of clinicians and slight notice is given to them in works upon Therapeutics. However, Dr. Horatio C. Wood (Therapeutics; 8th edition, 1891; page 722) makes a slight reference to the former, although considering the practice a very doubtful one.

Dr. Matthew Hay, who has contributed so much to our knowledge of the physiological action of the saline purgatives, asserts that the sulphates of magnesium and sodium do not purge when injected into the blood, or subcutaneously. In the latter case, he makes an exception in cases where in virtue of the injection a local irritation of the abdominal subcutaneous tissue is produced, "which acts reflexly on the intestines, dilating their blood vessels and perhaps stimulating their muscular movement." Dr. Hay also states that when injected into the blood, sulphate of magnesium is powerfully toxic to the system, "paralyzing first the respiration and afterward the heart and abolishing sensation,

*Advance sheets from the Ninety-six Annual Report of the Maryland Hospital For the Insane, 1893.

†Trousseau and Pidoux, Therapeutics, Vol. 2, p. 165. Wm. Wood & Co., 1880.

or paralyzing the sensory motor reflex centres."

The dose that M. Luton used, and found to act as an effective purgative, was ten centigrammes, equivalent to 1.54 grains. Acting upon a suggestion of Dr. Rohé, the Superintendent, to subject the question to a further clinical observation, 46 patients were selected, who suffered from habitual constipation, and required from 2 ozs. to 3 ozs. of a saturated solution of magnesium sulphate to produce one or more free movements of the bowels.

A two per cent. solution of Epsom salts in sterilized water was used. The hypodermic syringe employed had a capacity of two drachms, and when not in use, was kept in carbolized oil. Just previous to use, the needle was sterilized by steam. The dose varied from 1.86 grains to 4.5 grs. The smaller dose was first tried, and at each subsequent injection was increased ½ gr., in order to determine whether a slight increase in the dose would cause a free evacuation. It was found that the small dose acted as efficiently as the slightly larger.

In only one case was the largest dose (4.5 grs.) employed. This was a woman in whom 2 ozs. of a saturated solution of magnesium sulphate had previously failed to produce a movement. The subcutaneous injection caused a free evacuation in 7 hours.

The site of the injection was the left arm, at the outer aspect midway between the elbow and shoulder. In none of the cases was there any local reaction at the point of injection. A small swelling or slight tenderness was produced by the distention of the connective tissue, which disappeared in a few hours. No induration or abscesses occurred and the slight discoloration of the skin passed off in a day or two.

The injection was made 100 times in the 46 patients, and was sucessful 67 times or 67 per cent. and failed to act 33 times or in 33 per cent.

In 53 injections it produced one evacuation of the bowels; in ten, it produced two movements, and in four it produced three evacuations.

In only two patients were the injections a constant failure and both of the patients were of the class of melancholia with habitual constipation, who resisted nearly all purgatives.

In nine cases, the injection of 1.15 grs.—one-half the average dose—was repeated in one hour and caused two evacuations in five cases; in one, three movements; in two, one; in one, failed to act at all. This action shows that a small dose repeated in a short time has a better effect than one single dose of larger size.

In ten selected cases a comparison was made between the hypodermic injection of magnesium sulphate and the exhibition of a saturated solution by the mouth. In seven cases, or 70 per cent., the injection produced free evacuation; whearas one oz. given by the mouth acted only in three or 30 per cent.

The shortest time for the injection to produce an evacuation was three hours; the longest fourteen hours—the average being seven hours.

As to the consistency of the stools—45 may be said to have been watery, resembling those produced by a free saline purgative; in 11 they were mucilaginous in character, and the remaining 11 were the ordinary stools.

No action was noticed upon the general system following the injection.

In 50 injections noticed ½ hour after the injection, no rise in temperature, pulse or respiration occurred.

The indications for the use of the drug by hypodermic injection are obvious. In cases of gastric inflammation, where a purgative is required and the stomach rebels; in abdominal surgery, where a purgative by the mouth is apt to cause vomiting and in cases where the patient is unconscious, and unable to swallow, as in apoplexy, the hypodermic use of this purgative would be valuable.

In none of the 46 cases did such indications arise, but the work was done as an experiment and to demonstrate the value of the drug as a therapeutic agent when given subcutaneously. No explanation is offered as to its physiological action. That it does act when so given is a fact.

The effect could not be attributed to suggestion, as the patients did not know with what object the injections were made; besides, insane patients are notoriously difficult to influence by suggestion.

As stated before, the injections were always made into the arm, so that the aid of reflex irritation, in the sense of Matthew Hay, cannot be invoked in explanation.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD JAN. 5, 1894.

The 288th regular meeting of the Clinical Society was called to order by the President, Dr. J. Edwin Michael.

Dr. Julius Friedenwald gave a demonstration of the electrical illumination of the stomach. (See JOURNAL, page 265.) The instrument used consisted of a small incandescent electric light attached to a soft rubber tube, which enclosed the wires, and the other end of which was in connection with the battery. The stomach tube was first introduced and a litre of water poured into the stomach. The tube was then withdrawn, and the electric light-bearing tube inserted in its stead. The room was then darkened, and when the battery was turned on the stomach was brilliantly illuminated. It was plainly outlined—the whole anterior wall was easily inspected, blood vessels of the abdominal wall being beautifully marked and the movements of the stomach during respiration well demonstrated.

Dr. Osler thought this instrument would probably render valuable assistance in diagnosing very small tumors of the anterior wall which could not easily be found by palpation.

Dr. Geo. Preston related an interesting case of WIDESPREAD MUSCULAR ATROPHY.

Patient, a boy of 18, had been ill with cerebro spinal meningitis for four or five weeks, about four months previous to my seeing him. He was then feeling well enough and applied for treatment because of spinal curvature, which caused considerable deformity and interfered with walking. The muscles of the back were wasted and the deltoid and those of the arm and thigh were gone. Reflexes, both deep and superficial, were normal. Facial muscles were not affected. There was absolute deafness. No history of pain.

Dr. Harlan mentioned a case he had seen of absolute deafness attendant upon cerebro-spinal meningitis. Patient had also had syphilis, and at the time had a large polypus in one ear.

The polypus was removed and potassium iodide administered. In a few days he could hear well in the other ear.

It was the only case he had ever seen, of absolute deafness, where there was restoration to hearing.

Dr. Frank Martin reported a case of "Tubercular Knee-joint Cured by Injection of Iodoform Emulsion."

In November, 1893, I was called in consultation to see the patient, a child 22 months of age. Family history: Tuberculosis on mother's side.

Child: A picture of general tuberculosis, emaciated to a skeleton, hectic, high temperature, rapid pulse, persistent cough, lungs infiltrated, glands all over the body enlarged and knee on left side very much enlarged and full of pus.

In June the child had a cervical adenitis, which was considered tuberculous. During August lobular pneumonia developed, which cleared to some extent, but continued and was gradually followed by symptoms enumerated above. Two weeks prior to my seeing it, the knee began to swell and became painful. This steadily increased until the joint was quite filled and patella floating. It looked as if it would break on the outside. I gave doubtful prognosis, had the limb thoroughly cleansed, applied soap poultice and tied it up in bichloride. The next day I operated; opened the joint freely, washed out with bichloride 1 to 2000 and then with sol. boracic acid 3 per cent.; closed the wound, but before tightening the sutures injected 1½ oz. of sterilized emulsion iodoform 5 per cent. I then hermetically sealed the wound, covered with sterilized dressings and put on plaster splint. Slight reaction followed. On third day child had only temperature of 100°.

When dressed on 10th day wound was healed, no fluid in joint and joint perfectly movable. Kept up immobilization and prescribed cod liver oil and syrup iodide of iron.

To-day the joint is perfectly well, glands are decreasing in size, there is no cough and child is getting fat.

H. O. Reik, M. D.,
Secretary.
525 N. Howard St.

A servant who did not find her way very promptly to the kitchen one morning was visited by her mistress, who found her in bed, suffering from pain and violent sickness. She explained that she had a cold, and had taken some medicine which had been recommended for the children.

"How much did you take?" asked her mistress.

"Well, mum, I went by the directions on the bottle. It said, 'Ten drops for an infant, thirty drops for an adult, and a tablespoonful for an emetic.' I knew I wasn't an infant or adult, so I thought I must be an emetic; and the pesky stuff has pretty nigh turned me inside out."
—*Reflector.*

EARACHE.

If without indications for operative treatment, drop into the ear several times daily a little of the following: Menthol and camphor, of each twenty grains, in one ounce of albolene.

MARYLAND MEDICAL JOURNAL,

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BALTIMORE, JANUARY 27, 1894.

Editorial.

THE NEED OF A LARGER AND BETTER MEDICAL LIBRARY IN THIS CITY.

The JOURNAL has time and again urged the importance of greater attention upon the part of the profession of this State to the Library of the Medical and Chirurgical Faculty. This subject has almost become a hobby, which we fear we have ridden to the annoyance of many of our readers. If the cause we advocate is not a just and patriotic one, let our critics cast the first stone. We plead guilty of a sincere interest in this Library because we recognize that it is the most important medical institution in this State. We feel humbled by the reflection that so few members of the profession in the State view it from the same standpoint that we do. There are few who do not value this old historic pile of books and pamphlets, of charts, portraits and jars filled with monstrosities; and yet how few are there who are willing to come forward and lead in a movement looking to a rehabilitation of this work. We mean to cast no reflection upon the Library Committee; it is doing its work to the very best of its ability with the meagre assistance of the Faculty and of the profession. Books and pamphlets are added and the file of periodicals is kept full. So far, so good. But far more than this is needed. The Library is shelved in a building totally unsuited to its larger growth and so inaccessible that the daily attendance is less than a corporal's guard. The interest felt in its work languishes from this one circumstance more than any other, and unless some strong will comes along and pulls the Library out of this damp, musty old building its growth will remain at a standstill until the next century has come in.

The first step looking to a development of the Library must be taken in the direction of shelving it in better quarters. This once done a new interest will manifest itself. A better hall will encourage a larger support, a larger support will lead to subscriptions and donations, which will attest the value of the Library to the profession.

The journals of our country are full of praise for Professor Nicholas Senn, of Chicago, for his rich and valuable gift of medical books to the Newberry Library of his city. He has done for the profession of his city what Armour and Rockefeller have done for the general public. If we have no such men as Nicholas Senn in our city, we surely have several hundred men in our profession

here who will contribute to our Library in a smaller way, with an aggregate result equal to the great gift to our sister city.

Baltimore contains any number of generous and public-spirited men, who will add to the usefulness of our library if proper means are employed to enlist their interest. Let any one of the older and more eminent members of our profession, to the manner born, take the lead in this matter and in less than one year's time the profession of this city will own a Library and Hall that will redound to its glory and renown. The chief thing wanted in this movement is a leader of eminence, liberality and influence. We have many such men here, who are equal in public spirit and professional pride to Nicholas Senn and Robert Battey. Will not some one of these men lay a foundation for lasting fame and gratitude by leading a movement in the direction indicated?

REPORT OF THE MARYLAND LUNACY COMMISSION.

The work of the State Lunacy Commission, as shown by its eighth annual report, presents a most creditable condition of affairs and gives evidence of the thorough and careful methods employed by the Commission in the discharge of its important duties. When the Commission was organized, the insane in the State, considered as a class, were in a most deplorable condition. Many were housed in jails and almshouses, the asylums in the State being inadequate to meet the demands upon their resources. This condition of affairs has been corrected to a very large extent, so that at the present time much better care is exercised over these unfortunate people.

The Commission finds that during the past year the insane in all institutions have been cared for in a satisfactory way. The Commission reports that 3,150 persons who come within the lunacy act are now provided for in the different insane institutions and almshouses in the State, of which number 1,800 are indigent cases, and 400 are unprovided with hospital accommodations.

Of the total number, 550 are colored, or about two insane colored persons in every thousand; the ratio in white population being about one in three thousand.

The Secretary of the Commission, Dr. Lee, states that twenty years ago insanity among the colored people was almost unknown, since which time it has shown the remarkable increase above stated. This fact, Dr. Lee says, shows the importance of a separate asylum for the colored insane, who under present conditions fail to receive proper care and attention.

The Commission recognizes the urgent need for additional hospital facilities to meet the needs of the insane class, and appeals to the Governor to recommend an appropriation for this purpose. There are few more important measures before the General Assembly than the one suggested by the Commission in behalf of the insane of the State.

The JOURNAL has previously referred to this matter, and urged the co-operation of the profession of the State in

support of the bill introduced in the present Legislature for this purpose.

The Commission recognizes that insanity is a disease and not a crime, and it urges better care for the moral imbecile and epileptic, and hospitals in lieu of almshouses for the insane. Reformatory institutions for the crank, inebriate, feeble-minded and epileptic, conducted upon modern methods of treatment for this class, would be of vast service to this class of unfortunates, and a measure of economy as well as of humanity upon the part of the State.

The time has come when the suggestions of an intelligent Commission, having a humane consideration for the insane of the State, should receive prompt and careful attention.

The Commission has a benevolent and responsible trust imposed on it and we believe it is in thorough sympathy with its work. The profession should give a hearty co operation to its work.

Reviews, Books and Pamphlets

Chemistry and Physics. By Jos. Struthers, Ph. B., Columbian College School of Mines, N. Y.; D. W. Ward, Ph. B., Columbian College School of Mines, N. Y.; and Charles H. Willmarth, M. S., N. Y.; $1.00. (The Students' Quiz Series.) Philadelphia: Lea Brothers & Co., 1893.

Among the many quiz compends that were published within the last few years none can lay so just a claim to usefulness as this. It contains the essentials of chemistry, both inorganic and organic, and also of physics, with many illustrations. There is no book of its kind we can recommend so highly for thoroughness and clearness.

Medical Progress.

UNCONTROLLABLE VOMITING IN PREGNANCY.

Blanc (*Archives de Tocologie et de Gynecologie*, June, 1893) refers to the unfortunate position in which the practitioner is placed when in charge of a patient with uncontrollable vomiting during pregnancy. If performed too early, induced labor involves the destruction of a fetus which might have lived. If too late, after great emaciation, syncope and delirium have set in, the patient's death may be deferred for a very short time, or even hastened. The uterus cannot be made to contract in these advanced cases. Hence it must be emptied of its contents. Blanc attended a lady in her third pregnancy. The first had been normal, the second ended by spontaneous abortion at the fourth month, after uncontrollable vomiting. On this occasion the patient had reached the third month of pregnancy. The vomiting was very severe, there was fever, and the least movement produced faintness. Cerium, ice, cocaine, champagne and chloroform-water had all proved of no service. A laminaria tent was introduced; it set up contractions which soon passed away. Next day another tent was passed into the uterus. A day later a long strip of iodoform gauze was passed into the uterine cavity. At the end of twenty-four hours no contractions had occurred and the patient was delirious. She was placed under ether; then the uterine cav-

ity was scraped thoroughly, and the fetus, placenta and membranes removed by means of the curette. A plug of iodoform gauze was packed into the uterus after irrigation with bichloride of mercury solution. Subcutaneous injections of caffein and ether were then given. By the next morning the delirium had passed away, and the patient could take a few cups of cold milk and soup and a little champagne. At the end of two weeks she was restored to health.—*Univ. Med. Magazine.*

THE OLD EXCUSE FOR CHEATING THE DOCTOR.

Dr. I. Gutman, a reputable physician practising in the lower wards of the city, was called recently to attend a woman suffering from what appeared to be menorrhagia. After prescribing for her and leaving the necessary directions, he did not hear from her until three days had elapsed. In the meantime she had been delivered of a two months' fœtus by a midwife. He delivered the membranes and washed out the uterus, and the patient having been made comfortable he then requested his fee. Its payment was postponed on a flimsy pretext by the husband. The following day the fee was not only refused, but the husband secured the services of a detective, who arrested the doctor for malpractice and the production of abortion. As a consequence the daily papers paraded the fact under the usual sensational headlines, virtually branding the doctor as a quack and a criminal. The doctor was honorably discharged by the judge. These outrageous proceedings are now offset by a suit on the part of the doctor against the detective for ten thousand dollars damage. Under the circumstances who can be considered safe? Those who know Dr. Gutman and can testify to his good standing and high professional attainments, are at a loss to conjecture why he of all others should have been the victim of such dastardly persecution.—*Med. Rec.*

DIPHTHERIA OF THE STOMACH.

Dr. Soltau Fenwick exhibited before the Pathological Society of London a specimen of diphtheria of the stomach obtained from a child three years of age, who was admitted into the London Hospital in 1891 for an attack of croup. The illness had commenced on the previous day with symptoms of dyspnœa. On admission into the hospital there was considerable difficulty of respiration, but no membrane could be observed. Absolute anorexia prevailed, and when food was administered through a stomach tube vomiting invariably ensued. The vomited material never contained any trace of free hydrochloric acid. Tracheotomy was subsequently performed, and the patient died on the following day. At the post-morten examination primary laryngeal diphtheria was discovered, the membrane extending downwards into the finer ramificatians of the bronchial tubes. The pharynx and œsophagus were free from disease. The stomach was completely lined with adherent membrane, which extended for one-third of an inch through the pylorus. On microscopic examination the tissue presented the ordinary appearances of diphtheritic affection of the stomach. Diphtheria of the stomach was a rare disease, and occurred almost exclusively in children who were the subjects of pharyngeal

diphtheria. In such cases the gastric affection was stated by Kalmus to be found as frequently as 6½ per cent., but in this country the complication was not so often encountered. The chief points of interest in the case were: (1) the implication of the whole surface of the stomach; (2) the absence of membrane from the pharynx and œsophagus; (3) the clinical features of complete anorexia associated with vomiting and an absence of free hydrochloric acid from the contents of the stomach.—Mr. Shattock had seen a similar case, in which the entire gastric mucous surface was coated with membrane, though no exudation could be found in the œsophagus or in the upper part of the respiratory tract.

GONORRHEAL SALPINGITIS.

Walton (*Centralblatt fur Gynakologie*, No. 39, 1893), in a very complete monograph on this subject, refers to a latent form of gonorrhea, where the organism is saprophytic, and which exists in the male as well as the female. This latent organism, through an exciting cause, where a favorable culture medium is present, manifests itself, and thus it is that in the female the different uterine and adnexia inflammations are brought about. A pyosalpinx is commonly caused by a mixed infection of gonoccocci and pyogenic organisms, and this mixed infection can only be found early in the case, since the gonococci are later overpowered by pus cocci. The gonococci tend to migrate from the vagina into the cervix, and thence into the uterine cavity. The tubes are infected by uterine contraction or some therapeutic measure. German statistics show 23 to 28 per cent., and English and American 70 per cent. of all cases of adnexia disease to be due to gonorrhea. The inflammation always extends to the ovary, and may cause here a variety of conditions, from an oöphoritis to an abscess, and, also, salpingitis is always associated with perimetritis, *i.e.*, the inflammation extends through the tube-wall, causing a perisalpingitis, or else direct through the tube (ostium abdominalis) infecting the peritoneum, and at times causing general peritonitis. Usually the inflammation does not extend beyond the broad ligament, or where there is a pyosalpinx it may infiltrate between the two peritoneal layers of the same. The entire tube is never involved, but the inflammation is limited to the outer two-thirds, where the mucous membrane folds are more complex, and the growth of the micro organisms more favorable. Walton believes these cases should be treated antiphlogistically at the beginning, and later by hot irrigations (109⅔° to 113°F.), followed by an iodoform or ichthyol-glycerine tampon. He follows the operative technique of Lawson Tait, except where there are numerous adhesions. If hæmorrhage, or the pus, has escaped into the abdominal cavity, he irrigates with warm water at a temperature of 104° F., where Tait uses water at 98.3-5°F. In these cases he also uses a glass drainage tube.—*Univ. Med. Magazine.*

MANAGEMENT OF CONVALESCENCE OF TYPHOID FEVER.

In an article in the *North Carolina Medical Journal* Dr. W. E. Fitch says:

I never allow solid food until the temperature has been normal for at least ten days. I think this is a safe rule, leaning towards extreme caution; then I allow eggs, milk toast, milk puddings,

jellies, etc. Many leading practitioners allow solid food as soon as patient desires it, but I had a *lesson* in this matter while I was a student in City Hospital, Baltimore. A man about twenty-eight years old was convalescing very nicely. I was quite interested in this case. Two weeks after his temperature had been normal, and a few days before his intended discharge, he ate several mutton chops, and within twenty-four hours was in a state of collapse and died from perforation. I assisted Dr. W. G. Keirle, pathologist, with the autopsy, and found a small trasverse perforation at the bottom of an ulcer, which was in the process of healing. Since this I have been very chary about solid foods at the beginning of convalescence. It was quite a lesson to me.

Constipation is quite common during convalescence, and is best treated by enemata. Among the dangers of convalescence may be mentioned tuberculosis, which, as Murchison says, is more common after typhoid fever than any other fever.

EXPLAINED.

Howard's father is a physician, and one day when the doctor was out Howard and a little playmate were "playing doctor" in the real doctor's office. Presently Howard threw open a closet door and revealed an articulated skeleton to the terrified gaze of his playmate, but Howard himself was perfectly calm.

"Pooh, Walter!" he said to his playmate, "what you 'fraid of? It's nothing but an old skellington!"

"Wh-wh-where did it come from?" asked Walter, with chattering teeth.

"Oh, I don't know. Papa has had it a long time. I guess likely it was his first patient."—*Harper's Young People.*

TREATMENT OF HYDRONEPHROSIS BY THE FORMATION OF AN OBLIQUE FISTULA.

Witzel (*Centralbl. f. Chir.*, No. 47, 1893) advocates in the operative treatment of hydronephrosis the formation of a long oblique fistula resembling that developed in his method of gastrostomy, in which two lateral folds of the wall of the stomach are brought together by sutures over a piece of tubing, one end of which projects into the interior of the stomach, whilst the other end opens externally at a higher level. By this method, which the author states has now been extensively practised with very good results, it is intended to prevent the continuous flow of gastric secretion over the anterior abdominal wall. The extirpation of a large renal sac is regarded as a very serious operation, and, on the other hand, the formation of a direct fistula in cases in which some portion of the secreting tissue of the kidney is preserved, is likely to be followed by disagreeable results resembling those caused by a vesical fistula. A case is reported in which an oblique fistula was successfully established in a woman suffering from a very large renal cyst on the left side. The external incision was made in a line extending from the mammary line to the anterior axillary line, and the peritoneum was left intact. In conclusion, the author recommends the extension of this method to operations performed with the object of establishing fistulæ in the gall bladder, the urinary bladder, and the intestinal canal.—*Brit. Med. Jour.*

THE TREATMENT OF WARTS.

Professor Kaposi, of Vienna (*La Semaine Medicale*, No. 52, 1893), recommends, when the warts are solitary, removal by the knife, but when multiple, and especially on the face, he employs the applications of thuya occidentalis or fuming nitric acid. Vegetations are best treated by dusting with resorcin or salicylic acid, or a plaster of ten to twenty per cent. Resorcin, if applied for a long time, acts as a caustic, and may irritate the surrounding normal skin. These same topical applications are also excellent in keratosis palmaris and plantaris, even when they are not wartlike. In multiple warts of the face he employs the following:

℞.—Flowers of sulphur, grm. 20 (℥ v.)
Glycerine . . " 50 (℥ jss.)
Pure con. acetic acid . " 10 ℥ ijss.)
Apply locally to each wart.

They dry up, become bluish, and drop off. Continue this for several days. In mollusciform nævi electrolysis is the best treatment, except when the tumors are voluminous, when the galvano-cautery or caustic may be used.—*Med. Rec.*

INDICATIONS FOR CHOLECYSTOTOMY.

Frequently recurring biliary colic without jaundice, where medical treatment has failed. Persistent jaundice where the onset is ushered in with pain, and where recurring pains, with or without ague-like attacks, render it probable that the cause is gall stones in the common duct. Distended gall bladder from impaction of calculi in the ducts. Empyema of the gall bladder. Persistent jaundice, with enlargement of the gall bladder dependent on some obstruction in the common duct, even where the cause cannot be clearly made out.—*Robson.*

PERITYPHLITIS.

In 112 cases of perityphlitis, in which post-mortem examination was made, at the Berlin Anatomical Institute, 24 were found due to coproliths, 4 to foreign bodies, 29 to ulcerations. In 459 cases collected from literature corproliths were present 179 times, foreign bodies 16. Perforations of cæcum are rare, being found 29 times in 281 autopsies; four to five per cent. of those affected die.—*Renvers.*

ROTATION OF THE SPLEEN; REMOVAL.

At the General Hospital, Birmingham, on Jan. 2nd, Dr. Malins dealt with a very interesting case, in which he removed the spleen, weighing 2℔., 5oz. The patient, a woman aged thirty, was admitted two days previously with a tumor of the abdomen occupying a central position and dipping into the pelvis. There was some peritonitis present. The abdomen was opened in the median line and a peculiar condition was found. The spleen, altered in shape and position, was rotated on its attachment for about half a revolution; it was dark colored and much distended, and the vessels on the distal side of the strangulation were completely thrombosed. A prepared silk ligature was tied round the pedicle and the organ was removed. The abdomen, containing reddened fluid, was carefully sponged out and some adhesions of the omentum were tied. Up till the present time the patient has done remarkably well. The spleen is in the hands of Dr. Stanley, the pathologist to the hospital, and further details concerning the case will no doubt be published later.—*Lancet*, Jan. 13.

PYOKTANIN IN DIPHTHERIA.

C. Höring (*Memorabilien*, October 19th, 1893) refers to the treatment he adopted early last year in 27 cases of diphtheria, the results of which were published in the *Aerztl. Memorabilien*, vi and ix, 1892. Since then, Höring has continued to use pyoktanin, and claims excellent results. The practice was to apply a 3 per cent. solution two or three times daily to the pharynx and downwards to the epiglottis, the retention of the liquid in young children being secured by immediately placing their heads low, thus aiding the swallowing of the liquid. Otherwise the drug was not administered internally, nor was it directly introduced into the affected tonsil. Simultaneously the patients are syringed with lime water, or are allowed to use it as a gargle or inhalation, while salicylate of soda is given internally. When the nose is affected, a tampon soaked with the solution is retained in the cavity, and in milder cases the application of pyoktanin to the pharynx, etc., is the only treatment followed. In support of his practice, Höring says he has found even a 1 in 1,000 solution to destroy the Klebs-Loeffler bacillus, as also the more active streptococcus, the latter in the course of half a minute. In practice, the local effects are antiseptic, healing, and destructive to the false membrane, the general results being diminution of pain and pyrexia without the production of toxic symptoms. The present cases enumerated are 112, two of which succumbed for reasons explained; the remaining 110 cured cases included many serious cases which had been despaired of. The symptoms, spread of contagion, and sequelæ, are quoted in support of the diagnosis. The author, in view of his experience, supported by that of others, regards pyoktanin as a specific against diphtheria.—*Brit. Med. Jour.*

LA GRIPPE.

A physician who had just passed through an attack of this distressing disease thus writes to a friend: "Did you ever have this infernal disease that they called the grippe? If not, don't. I have been through it for the last six weeks and am ready to give my friends the benefit of my experience. It is certainly the most diabolical malady that ever got out of Pandora's box. If the old girl has anything worse in reserve I trust she will keep the lid of her Saratoga safely locked and then kindly sit on it. Sneeze, freeze to death, burn up, have your energy sapped, let all the clouds of heaven lower over your head, get on familiar terms with all the blue devils that ever escaped by volcanic exit from equatorial eternity—do all of this and keep it up for six weeks, and then you can intelligently listen to a lecture on *la grippe*. Cerebration becomes altogether of the too conscious sort for literary work."—*N. Y. Med. Jour.*

Medical Items.

A new edition of the National Dispensatory, by Lea Brothers & Co., is announced. It will include all the changes made necessary by the new Pharmacopœia. Professor Charles Caspari, of Baltimore, succeeds the late Professor Maisch in the section of the work heretofore prepared by that *savant*.

The trustees of the Santa Fe Hospital have decided to erect a building in Topeka this year, and work will be commenced in the early spring. The building and grounds will cost $100,000, which sum is on hand.

Baptism by immersion was performed in an unusual manner in a Pennsylvania town not long ago. A patient too ill to leave his room was desirous of baptism. A large portable tub was filled with water at the bedside. The man was lowered into it on a sheet quite in the Brandt manner, and the ceremony successfully performed.

At the annual meeting of The New York Ophthalmological Society held on Monday, January 8th, the following officers were elected: President, Dr. W. S. Dennett; vice-president, Dr. Frank N. Lewis; secretary and treasurer, Dr. D. W. Hunter; committee of admissions, Dr. Henry D. Noyes, Dr. Arthur Mathewson, and Dr. J. B. Emerson.

We are informed that it costs the people of the United States each year to be born, $25,000,000; to be married, $300,000,000; and to be buried, $75,000,000; while to get drunk the people pay $900,000,000. It is also said that this bill for drunks is larger than the bill for all the bread and meat consumed by the same people.—*St. Louis Med. and Surg. Jour.*

Doctors' bills are said to be classed as debts of honor in Austria, China and Sweden. They are left, as gambling debts are here, so far as the law is concerned, to be paid or not, according to the inclination of those incurring them. This way may not, however, be entirely a disadvantage, because it is well known that such obligations are frequently paid where legal debts could not be collected. —*Boston Med. and Surg. Jour.*

The death of Professor Rudolph Kaltenbach is announced. He was professor of gynæcology in the University of Halle, where he succeeded Olshausen in 1887. In 1867 he became the assistant of Hegar, then at Freiburg, and the two worked together as clinicians and authors for many years. He went from Freiburg to Geissen in 1883. His *Lehrbuch der Geburtshülfe*, published in 1893, is a work very highly esteemed in Germany.

Dr. Richard C. Norris has been elected physician in charge of the Preston Retreat, in succession to Dr. Joseph Price, who has resigned. Dr. Norris was graduated from the Medical Department of the University of Pennsylvania in 1887, and was at once elected a resident physician in the Philadelphia Hospital. He has for a number of years been an instructor in obstetrics in the University of Pennsylvania, and is also one of the editors of the *Annals of Gynecology and Pediatry.*

Dr. Lewis E. Atkinson, of Middletown, Pa., for ten years a member of the House of Representatives from the Eighteenth Congressional District, will be a candidate for the nomination for Governor at the next State Republican Convention, and will shortly make a formal announcement of his candidacy. The doctor is a cripple and walks on crutches. He was defeated for the nomination for Congress in his district two years ago by Congress-

man Mahon, of Chambersburg, and has since lived quietly at his home in Mifflintown.

The Hartford, Conn., Medical Society held its annual meeting at the residence of Dr. Gurdon W. Russell. January 1. By the terms of the will of Mrs. Mary C. Hunt the Society will receive $20,000 for a new building, providing a lot is secured within two years. A subscription for a lot was started, Dr. G. W. Russell heading in with $1,000, and Dr. G. P. Davis following with $500. A canvass will be made and it is expected that the balance will be easily raised.

Biliousness Cured.—Dr. Slasher has been treating a patient in Bellevue Hospital for disease of the liver, and the patient died, and when the autopsy was held it was discovered that while the liver of the victim was in a perfectly healthy condition, his lungs were dreadfully diseased.

Some of the students who were present began to snicker, whereupon Dr. Slasher remarked:

"Gentleman, what else did you expect? This man's liver was diseased, but, as you see, I cured him completely. That he died of tuberculosis is something with which I had nothing to do."—*Texas Siftings.*

There is on foot a movement by the Medical Alumni of the University of Virginia for the presentation to the University of an oil portrait of the late Prof. W. B. Towles, to be hung in the Library, where are to be found "the portraits of those men who have been most closely connected with the growth and success of that institution." The committee having in charge the solicitation of funds are Drs. Stuart McGuire, J. Allison Hodges and Charles V. Carrington, all of Richmond. Should a communication by any accident fail to reach any medical alumnus, we take the liberty of stating that the limit of subscriptions is placed at $2.00.

It is a notable fact that while the subscriptions to the memorials of Monsieur Gounod and Dr. Jowett have rapidly reached most highly satisfactory figures, upwards of £4,000 in each case, the memorial to Sir Richard Owen, inaugurated under Royal auspices and most professed approval of the civilized world, as expressed in the periodical press, has as yet reached only £1,000. The contrast is somewhat humiliating to lovers of science and to those who had supposed that the memorial to a man whose eminence had shed the highest lustre upon his country and whose services were recognized throughout the world would readily receive adequate support. Evidently, however highly science might be thought of and spoken of, those who admire it are not very ready to back their opinions.—*Brit. Med. Jour.*

At the last meeting of the Medical Journal Club, Dec. 11, the following resolutions were passed on the death of Dr. W. J. Jones:

Whereas: Death has removed from our midst Dr. Wm. J. Jones, founder and first president of the Medical Journal Club of Baltimore, we, the undersigned committee of this organization, desire to make known the following resolutions.

First: That in the death of Dr. W. J.

Jones the Medical Journal Club loses one to whose interest and zeal it is largely indebted for its successful history.

Second: At the loss of a member of an association so closely united by professional and social ties, we feel it our duty to make expression of our personal sorrow.

Third: The profession at large is by his removal deprived of the services of an honorable, conscientious and faithful worker.

Fourth: Resolved, further, that a copy of those resolutions be presented to the family of the diseased and be published in the MARYLAND MEDICAL JOURNAL, and that the Club be represented at the funeral services by a committee.

John C. Hemmeter, Chas. W. Mitchell, Frank Martin, Committee.

A letter directed to the undersigned by the Secretary-General of the Eleventh International Medical Congress and dated December 19th, 1893, contains the following communications: "American members will pay on the English, French and Italian railways single fares for double journeys, and will obtain a reduction of twenty per cent. on fares for Italian round-trip tickets. The documents required for their identification will be sent to you in January, and Americans intending to visit the Congress will have to apply to you for them. Full particulars concerning the journeys will accompany the documents. Messrs. Thos. Cook and Son, London, Paris, Rome and Naples, should be applied to for accommodation and for tickets for the excursions at Rome, Naples, and to Sicily. Such excursions will be arranged at Rome under the guidance of Mr. Forbes, member of several scientific societies and correspondent of the *Times*—for Naples, three days, including Vesuvius, Pompey, Capri, Sorrento, Castellamare, Bajae, etc.—for Sicily, ten days from Naples, including Messina, Taormina, Catania, Girgenti, Siracusa, Palermo, and return to Naples. The fares for members of the Congress will be considerably reduced and comprise hotel accommodations, carriages, guides, boats, etc.—about 70 frcs. each, for the three days, and 285 frcs. for the ten days. Full particulars concerning these excursions will be contained in a leaflet to be added to the instructions and documents for the journey."

From former communications the following are herewith quoted: The members' fee is five dollars, that of their wives or adult relations two dollars each. Checks or money orders may be sent to Prof. L. Pigliani, Rome, Italy. Credentials have been promised in the near future. When they arrive (none were received last year), they may be too late for many who are started or about to start. The undersigned, who is not informed of the cause of delay, proposes to supply in as official a form as he thinks he is justified in doing, credentials which are expected to be of some practical value. The North German Llyod has promised to recognize them. It is suggested, besides, that a passport may increase the traveler's facilities.

Only the North German Lloyd (22 Bowling Green) and the Compagnie Generale Transatlantique (3 Bowling Green) have thought fit to grant any reductions to Congressists.

The reductions on Italian railways are available from March 1st to April 30th. A. Jacobi, M. D., 110 W. 34th Street, New York.

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THE THERAPEUTICS OF TO-DAY.*

BY JOSEPH T. SMITH, M. D.,
OF BALTIMORE.

The twin subjects of Materia Medica and Therapeutics are exciting so much attention at this time that we open up the subject with the hope that it may give rise to profitable discussion.

As reported in the English journals, many of those who delivered the opening addresses at the colleges took these as their theme.

The remarks of Dr. Charteris, of the University of Glasgow, and of Dr. Brunton, of St. Bartholomew's, London, were reported at length, and were of special interest.

Dr. Lionel Beale, in his address, note the active work which is carried on in the Botanical Laboratory at King's College.

Dr. Charteris notes the use of carbolic acid in typhoid fever, the thyroid gland in myxœdema, and concludes by saying, "With pure drugs and with a rational interpretation of symptoms, we seem to see therapeutical progress all along the line."

In reading the early works on materia medica and therapeutics, one cannot fail to be impressed with the detail in which drugs, their combinations and methods of use, are dwelt upon. Our modern works on the use of remedies present a marked contrast to those of fifty, and even thirty years ago.

Shaw, in his "Practice of Physic," published in 1753, devotes less than one

*Read before the Clinical Society of Maryland, January 19, 1894.

page to the definition, cause, diagnosis and prognosis of rheumatism, and three and one-half pages to its treatment, and these are mostly taken up with drugs and their many combinations. In considering the same disease, Loomis, in his "Practical Medicine," published in 1890, occupies nine and one-half pages with the morbid anatomy, symptoms, etc., and only three pages with treatment.

In Shaw's "Practice," his notes on treatment consist chiefly of prescriptions; in the article referred to there are 16. In Loomis' work not a single prescription is given; single drugs are spoken of, and if a combination is noted it is usually of the simplest kind.

What is the cause of the difference between the therapeutics of 1753 and 1890 ?

We note the extremes for the sake of emphasis. The change has been a gradual one, and a comparison of any ten years will show it.

Does this mean that we are finding out that remedies are comparatively useless, or if this is not the case, what have been the influential elements in effecting the change?

If the publication of books is any index of professional opinion we can answer the first part of the question in the negative. Possibly never before have so many volumes been published on materia medica and therapeutics; indeed, the works upon these subjects compare favorably with, if they do not exceed in number those upon any other subject.

A list of books published by one of the largest houses has: surgery 16; practice 12; materia medica 12; obstetrics and gynæcology 11. The demand for works on materia medica and therapeutics is greater than ever before, and the recent publication of Hare's Therapeutics in three volumes is an indication of the great activity that is going on in this field.

If we note the individual drugs we can answer the first question also in the negative. While a large proportion of the old drugs still continue to hold their place, never before has so much time and labor been given to the discovery of new. Cerna's work on the "Newer Remedies," published in 1893, contains 303 different drugs, all of which have more or less value, and many are in constant use, as aristol and europhen, antipyrine and phenacetin, guaiacol and its salts. Not many years ago opium was almost our only sleep-producing agent; now we have many—chloral, croton-chloral, hyoscíamus, cannabis indica, paraldehyde, urethane, hypnone, the many bromides, camphor monobromate, hop, lettuce, sulphonal; and the latest, trional, of which Dr. Mattison says: "I have found the effect of trional more certain, pronounced and prolonged than that of sulphonal, and my experience, with that of foreign physicians, warrants me in thinking it the most powerful hypnotic now at our command."

Not only have these new drugs been discovered, but no less labor has been spent in differentiating their actions upon the economy. Opium is still our great analgesic; chloral and the bromides are spinal sedatives, the one affecting chiefly the motor and the other the sensory elements of the cord; sulphonal, according to Shick, exerts its chief energies upon the higher nerve centres; and paraldehyde, which Brunton classes with general anæsthetics.

A notable change in many of the

modern works is the abandonment of the system of classification, and the arrangement of the drugs in alphabetical order. How far this is desirable might be questioned, but it serves to show in another way the activities that are at work. A notable change at this time is that in regard to destructive agents.

Formerly agents which caused destructive metamorphoses within the body were called for, and bleeding and mercury held sway. At this time all is changed, for while we direct our attention still to destructive agents, we strive to destroy without, not within the body. Thus it is that there is a large and increasing list of agents—the antiseptics and germicides, which are essential elements in our new system of therapeutics. The success which has attended the use of such destructive agents is a matter of every-day experience. Surgery, with all of its modern triumphs, exists because the materia medica of to-day exists.

While much of necessity still remains to be accomplished, the field of therapeutics has been well cultivated, and had it not kept fully abreast of the times, had it not met the demands of the new surgery, many of the greatest achievements of the latter could not have been attained.

Modern materia medica has served to make more possible a system of preventive medicine; no one doubts but that typhoid fever, diphtheria, small-pox and scarlet fever could be abolished from our daily visiting lists if modern therapeutics, with all its power, was brought to bear upon them.

Dr. B. W. Richardson, in the preface to his work on "Preventive Medicines," published in 1884, says: "I confess for my own part I have had great sympathy with the curative school in which I was born and bred and with which I remain too closely associated ever to be disconnected from it.

"At the same time, the truth must now be candidly admitted, that the system of relieving mankind of its misery and load of diseases can no longer rest alone on what is called curative skill. We have entered an era in which the steady effort must be, not only to cure disease but to cure cure. The men who have proclaimed the art of prevention, based upon the art of learning the antecedents of the phenomena of diseases and the reason why diseases are developed at all, are right in principle, however widely they may sometimes have erred in details of facts and endeavors after practical attainments for the realization of which they were not ready and for many a long day will not be ready.

"The grand work of this era is to reconcile the two different schools; to systematize the preventive part of medical science, so far as that is now known, to bring the preventive part into entire accord with the remedial; to let the world at large understand the inter-relationships which exist between the two parts, and by a sympathy of action, based on knowledge, to enable every man and woman to assist in that part which tends towards prevention."

Modern therapeutics has been no small factor in giving us "a system of relieving mankind of its misery and load of disease" without its resting alone on curative skill; it has been no small factor in bringing "the preventive part of medcine in accord with the remedial."

It is needless to give examples of what has just been said; many will suggest

themselves to you. Pardon me, however, if I give one, as it is forcible:

When I entered upon my service at Bay View last year there were several cases of erysipelas; this showed a tendency to spread, one or two new cases occurring. The disease attacked the face mostly—in one the leg and in one the face, neck and upper part of the trunk.

Curative, if the word may be allowed in this connection, iron internally with ichthyol and vaseline locally, was joined with preventive medicine, the admission of no new cases into the ward and its thorough disinfection. The result was all that could have been desired; the disease disappeared from the Hospital.

In looking thus at modern therapeutics, we find that we have not outgrown the use of remedial agents—our methods only have changed. The next point of inquiry is, What have been the influential elements at work in effecting the change?

An eminent writer has said, "everything in medicine is connected or should be connected with therapeutics. . . . Anatomy, physiology, pathology, etc., must all converge towards therapeutics as a commom centre. Each of these has an effective value only in proportion to the succor it gives in the treatment of disease."

This being true, therapeutics is essentially a dependent part of medicine, but it has always responded promptly to the demands made upon it.

During the synthetical period therapeutics felt the influence of the times, and we have left, as the result, certain specifics which act upon certain physiological functions, as the emetics, diuretics, diaphoretics, etc.

The synthetic soon gave place to the anylitic period and therapeutics felt again the influence of the new views; today we follow in some respects its teachings. In pneumonia, therapeutics comes to our aid and in response to our anylitic method of viewing the disease, we can reduce the temperature, relieve the pain, control the cough and bring the majority of our patients through the ordeal in comparative comfort.

In the third or expectant method, therapeutics stands as an obedient servant. Therapeutics has felt in a very marked manner the present belief in the origin of many diseased conditions, and a synthetic system of preventive medicine is struggling hard for ascendancy.

Did time allow we might show how pathology has exerted its influence.—In the days of the humeral pathology, how mercury, bleeding, the diuretics and diaphoretics were found to relieve the body of its morbid humors.

When Virchow revolutionized the belief of the medical world with his cellular pathology and when, in part as an outcome of that, we have the belief of today, in the microbic origin of many diseases, how we find our therapeutics change and we are trying under new conditions to destroy the specific cause of disease.

It will thus be seen that more work is being carried on in this field than ever before and that it is to-day feeling the effect of the new doctrines and beliefs and is endeavoring, as it always does and must, to accommodate itself to them.

Increased care and attention are necessary in order that we may be supplied with pure drugs and these can only be

secured when the commercial element is not the controlling one with the manufacturing chemist and pharmacist, as it is not with the scientific physician.

Our most pressing need is a more accurate knowledge of the action of drugs, and laboratories only can supply it. Possibly the greatest good that such laboratories could accomplishwould be in furnishing us with information as to the value of new drugs, and in helping us to obtain such a knowledge of the drugs now in use and which are of doubtful utility that we might be able to lay them aside with confidence. The signs of the times are that such laboratories will be established and will form a part of the University work. Dr. Beale speaks of the good already done in this direction at King's College.

1010 Madison Avenue.

SUBCUTANEOUS INFUSION OF A NUTRITIVE SALT SOLUTION IN CASES OF REFUSAL OR INABILITY TO TAKE FOOD.*

BY MILTON D. NORRIS, M. D.,

Assistant Physician Maryland Hospital for the Insane.

Although the intra-venous and subcutaneous injection of large quantities of fluid, for the purpose of keeping up the blood pressure, has long been practised, I believe the idea of administering nutriment by subcutaneous infusion originated with Dr. George H. Rohé and was first used in this Hospital.

Ilberg and Lehman in Germany, within the last year, report several cases in which good results followed the hypodermic injection of 600 cubic centimeters of a saline solution in the fasting insane, but these gentlemen used a simple salt solution without any actual nutriment.

In the case I am about to report the solution used was composed of 12 to 14 ounces of sterilized water, to which after partially cooling were added the whites of two eggs and 30 grains of common salt. This was filtered through cheese cloth. The resulting liquid had about the appearence and consistency of simple syrup and would coagulate on being heated. Only the whites of eggs were used because they do not require any previous digestion, but can be directly assimilated.

An ordinary stomach tube and a medium sized aspirating needle were the only instruments employed in giving the infusion. No force, except that of gravity, was used and generally only one puncture of the needle was required. The loose tissue over the gluteal region was always selected as the point of puncture and the time required to inject the 14 ounces was never over 15 minutes. The injection of this large quantity of fluid in such a limited area would of course make a considerable swelling, but this would disappear in an hour and there was not a single case in which any bad effect followed the injection.

The subcutaneous method has the advantage over the intravenous of a gradual absorption of the fluid and therefore no danger of overwhelming the heart, besides there is no danger of emboli or the admission of air into the veins and this method can be used by any one with a little care, while the intra-venous can only be used by the skillful.

*Advance sheets from the Ninety-six Annual Report of the Maryland Hospital For the Insane, 1893.

The first case was M. J. K., male, aged 50 years. Case of chronic mania, who was constantly dirty, noisy and tearing. He had been fed for some time by means of the stomach tube, but became weakened and more emaciated every day. He was given 14 ounces of the fluid at intervals of 4 days and fed on the intervening days. His appearance and condition greatly improved and on the day after the third infusion he began to eat and has given no trouble since.

Case 2. W. P., male, aged 65, case of dementia, suffering from Bright's disease. At time of admission his pulse was 64 and every attempt to swallow was followed by vomiting. All efforts to feed by the mouth were stopped and he was given the infusion every day for 4 days, at the end of which time there was marked improvement; his pulse being 80 and much stronger. He was then able to retain food on his stomach, but from time to time had attacks of vomiting and after several months again became so weak that the infusion was repeated with good results.

Case 3. T. C., male, aged 18 years, case of acute mania. Admitted January 24, 1893, at which time he was constantly swearing, crying or singing and biting at every one who came near him. He was in a very weak and emaciated condition owing to his refusal to eat for several days previously and was fed the usual quantity of milk and eggs by means of the stomach tube, but soon vomited all he had taken and during the next 24 hours was not able to keep anything on his stomach, although several attempts were made. All efforts to give food by the mouth were stopped and 14 ounces of the infusion given daily for 3 days, during which time he received no other nourishment. On the fourth day he was much stronger and perfectly quiet, pulse good, tongue clean and complained of being hungry. He was given food, which was retained, and he ate regularly with a good appetite afterwards. This patient has since been discharged from the Hospital cured, but I believe he would have died from exhaustion if the infusion had not been used.

Case 4. A. E. C., white, female, aged 52 years, case of acute mania. Patient was very violent and was fed with a stomach tube, but this had to be abandoned on account of an abscess involving the mouth and throat. She was given the infusion on three successive days, but died on the fourth day from exhaustion caused by the extensive inflammation of mouth and throat.

Case 5. E. D., white, female, aged 48 years, case of epileptic insanity. The epileptic seizures occur once in two or three months and are followed by a period of depression. During one of these depressed periods she refused all food for several days and was given the infusion on three successive days. She improved considerably and began to eat on the fourth day.

Case 6. R. L. T., white, male, aged 31 years, case of simple melancholia. This patient refused to eat and despite persistent feeding with duck and stomach tube he became weaker and took to bed in a very weak and emaciated condition. His secretions were foul and vomiting occurred frequently. The infusion was given on four successive mornings and although during this time, over 100 hours, he did not take any food into

his stomach, his condition in every respect was better than it was before receiving the infusion. His tongue became moist and clean, pulse stronger and mental condition was much better. He asked for food and has so much improved that he now has liberty of the grounds and will most likely be sent home in a short time. This patient was discharged recovered on November 19, 1893.

It is well known to every alienist that certain cases of melancholia with refusal of food not due to delusions will gradually emaciate and die in spite of the most persistent artificial feeding, and it is in these cases that the subcutaneous infusion of nourishment will find its greatest use.

In cases of delirium tremens where the stomach will not tolerate anything, this method affords an excellent means of keeping up the patient's strength during the three or four days that the stomach is resting; also in severe cases of vomiting of pregnancy and any case where the stomach must have rest, this method of giving nourishment will be useful.

It has the advantage over rectal feeding of not being so dangerous nor so disagreeable to the patient and of being more certain in its effects; besides it stimulates the heart and increases arterial tension, which is important in cases that are very low, as most of those will be in which this method is indicated.

I believe this method of administering nourishment can be used to advantage in a considerable number of cases by both the alienist and the general practitioner.

SIR ANDREW CLARK AND HIS METHODS OF WORK.

The London *Lancet*, in speaking of Sir Andrew Clarke, says:

The very characteristic address to students of the London Hospital on the treatment of fibroid lung disease (one of the series of instructions in clinical medicine given at that hospital by the late Sir Andrew Clark), which was published in the last issue of the *Lancet*, suggests a brief consideration of the principles upon which he treated disease and of those qualities which made him so widely consulted a physician. He was rather fond of saying that medicine is the most unprincipled of arts. Be this as it may, there are some great general principles underlying Sir Andrew Clark's treatment of disease which had much to do both with his own success and that of his treatment, and which are stated with his usual felicity and clearness in the address. His great fundamental idea of treatment was that it must have regard to the laws of health. "The first observation I make to you is a curious but an important one: it is that the laws of health are not suspended because a person is sick." He believed that most cases of disease had their origin in some violation of the laws of health; and of those laws he was a constant student; he reasoned with his patients as if they studied these laws, too, or were capable of so doing. It was almost a daily practice with him to read a portion of some work on physiology, as it was a daily prescription to each patient that he was to obey the laws of "physiological righteousness." It would be difficult to over-estimate the effect his advice and his authority had in impressing well-to-do people with the con-

viction that the luxuries they enjoyed were a source of risk and often of disease to them. Few patients left his consulting-room without receiving carefully written instructions regarding diet, and though these generally allowed three liberal meals a day they were not immoderate and unlimited ones. He tells his students that if it were possible to divide patients suffering from acute diseases into two classes, the first class consisting of people in circumstances just sufficiently comfortable to live and the other class of the rich and the great, it would be found that the mortality amongst the latter class greatly exceeded that of the poor and those just sufficiently well-to-do. His teaching about alcohol, well defined in the address under notice, was uniform and sound His remarks had immediate application to cases of fibroid phthisis, but they were very much the same as he used in other cases. If the patient is equally well without alcohol it is much better that he should not have it. He was too good a physician not to see that some cases were greatly benefited by small quantities of alcohol; but these must be given at the right time. On this point he is very explicit, and represents all sound medical teaching. The right time he defines to be certainly not between meals or on an empty stomach. "I entreat you," he said to his hearers, "to avoid either giving or assenting to the giving of alcohol in any form under such circumstances. Give the alcohol at dinner or supper, and at no other time." It will not be the least service Sir Andrew Clark rendered to his generation that with all his authority he insisted on temperance and did his best to remove that blind belief that the weakness of disease is to be overcome by indiscriminate eating and drinking. He impressed on his patients and on the public audiences that attention to such things has far more to do with health than great things: "It is not so much the big things of life, it is the little things that make and unmake health."

Another very striking feature of Sir Andrew Clark's therapeutics was his estimate of the importance of work. In the last generation one of our great surgeons distinguished himself by a work on the surgical advantages of rest; but in this we have had a physician who has told all his patients that to the measure of their ability they are to work. Like another prophet of this age, he has enjoined and eulogized work, not only as a duty and a pleasure, but as a condition of health. Even patients with fibroid lungs are to do a little work. At the London Hospital the patients were told to go up and down stairs for the sake of expanding the contracted lungs, which came to be called the "stair treatment;" for even in the case of a delicate organ the fullest regulated discharge of all its functions is the cardinal condition of its highest life. Some of his friends thought that he himself did too much work, but he would never admit it, and he was fond of saying that he had never known anybody to be the worse for work. In this very address he describes how his contemporaries prognosticated his early death because he worked hard and ate little, and how thirty-eight years afterwards most of his contemporaries were dead and he himself was one of the few survivors. On the other hand, he admitted that worry is injurious. "La-

bor is life, but worry is killing" and he imposed on his patients, as a duty, that by an effort of will they should—as he said they could—cultivate quietness of mind. The fact is that he in his capacity of physician took into consideration the character of his patients, all their conditions and circumstances, and even their sins and temptations, and on these founded a large part of his advice, which enabled the patients as a rule to live longer and where this was not possible to die more easily. As he said nine years ago,† in a remarkable account of the case of a vivacious old gentleman of eighty-two years of age suffering from relapsing pneumonia who recovered after having nine or ten rigors, "I first attended to the man and then to the malady." Every case was unique in his view and had to be treated on its own merits and according to special circumstances. This very case showed that he had his own favorite prescriptions, and that despite his strong teaching on the abuse of purgatives he did not despise the use of colocynth and blue pill in order to prepare the way for brandy and quinine, and poultices, and an alkaline saline, to be afterwards fortified by the addition of ammonia, and all to be subordinated to the natural conditions for promoting recovery. "The food was given in relays, not too liberally or too frequently"—avoiding a mistake often made with the best intentions, which loads and narcotizes rather than helps the patient. He endeavored to maintain the vigor of the circulation, to shut out noise and fussiness, and by light and fresh air to keep the organism in the best possible state for recovery. We have said little of Sir Andrew Clark's use of drugs, but he used them freely and skilfully. We have the authority of Dr. Lauder Brunton for saying that he was a master of therapeutics, that he kept himself abreast of the newest remedies, and that he used old ones with remarkable skill. His instructions on fibroid phthisis include several prescriptions, which he mentions in terms which show his confidence in them.

We should miss one great secret of Sir Andrew Clark's power over his patients if we did not recognize two or three of his other great qualities—viz., the confidence and authority with which he spoke, which were based on the soundness of his general principles of treatment, and the cheerfulness with which he regarded even the graver classes of cases which came before him. Patients suffering from heart disease and lung disease went to him, and received, not prognostications of evil, but materials for hope and comfort. His paper on Valvular Disease, read at the Brighton meeting of the British Medical Association, showed not only how carefully he noted the individual cases which came before him, but what an eye he had for the hopeful side of disease. He had seen 684 patients suffering from valvular disease without symptoms or suffering, and who had come to him for other complaints—viz., indigestion (272), rheumatic conditions (57), gout (22) nervous complaints (44), eczema (17), and phthisis (4). Heart lesions in young subjects, he said, were considerably improved if development was not complete. He found in such patients fit subjects for his advice about physiological living and sent them away with

†Lancet, Dec. 20th, 1884.

the impression that if they obeyed his suggestions they would live little less happy or less long lives than other men. The physician is bound to regard disease in its most hopeful aspects; patients go to him, not that he "may cast the fashion of uncertain evils" and accidents, but for suggestions of hope and help.

A PRECAUTION IN THE USE OF COCAINE AS AN ANÆSTHETIC.

In a recent number of the *Centralblatt für Chirurgie* we find an abstract of an article by Dr. Gauthier, published in the *Gazette des hôpitaux*, on a means of preventing the unfavorable after-effects of cocaine when it is used as a local anæsthetic by injection. This consists in the addition of one drop of a one per cent. solution of nitroglycerin to the injection. The author goes on to say that nitroglycerin dilates the blood-vessels of the brain in the same way that amyl nitrite does; in the course of a few minutes after the injection of two or three drops of a one per cent. alcoholic solution the skin of the face is seen to grow red and hot, the conjuntiva becomes injected, and the patient complains that his head feels as if it were going to burst. M. Gauthier has taken advantage of this action, antagonistic to that of cocaine, for the last two years.—*N. Y. Med. Jour.*

THE OPERATIVE TREATMENT OF HERNIA IN CHILDREN, WITH A REPORT OF FIFTY-ONE CASES.

Coley, in *Medical Record*, July 1, 1893, reports his cases of operation for hernia in children. He gives the following indications: (1) Cases of adherent omentum. (2) Cases complicated with reducible hydrocele. (3) Cases irreducible and strangulated. (4) Cases unable to obtain the care and attention requisite for successful mechanical treatment. (5) Cases when mechanical treatment has been faithfully tried for a number of years without benefit. Of 250 cases under the age of 14, there were but two deaths, 8-10 per cent. There were nineteen relapses, or 8.6 per cent. The author has operated in forty-six cases, forty-two being non-strangulated, between the ages of 4 and 14 years. In all there was but one death, that of a strangulated hernia in a baby 8 weeks old. Thirty-two were operated on by Bassini's method, kangaroo tendon being used for the buried sutures. Only two cases suppurated, and in these the silk suture was used. After the operation the child is encased in a plaster of Paris dressing from the umbilicus to the foot. Only two relapses are recorded, one following a Czerny and the other a Bassini operation, when silk sutures were employed instead of the kangaroo tendon.—*Univ. Med. Mag.*

REINFECTION WITH SYPHILIS.

At a recent meeting of the Royal Society of Physicians of Vienna, Neumann (*Wiener medizin. Presse*, 1893, No. 49, p. 1943) presented a case of reinfection with syphilis, which had been under observation in the primary attack four yerrs previously. The case was utilized to demonstrate the curability of syphilis, and, as the treatment consisted of ten inunctions and four injections of calomel, as an argument against the protracted method of treatment.—*Med. News.*

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BALTIMORE, FEBRUARY 3, 1894.

Editorial.

THE VALUE OF ANÆSTHESIA IN THE DIAGNOSIS OF INTRA-ABDOMINAL CONDITIONS.

A thorough relaxation of the abdominal muscles is essential to a careful examination of intra abdominal organs. As a thorough examination of the abdomen is a matter of impossibility in many individuals, owing to an involuntary contraction of the abdominal muscles, it is necessary to relax the muscles by destroying volition and involuntary contraction.

For several years past the writer has employed anæsthesia for this purpose and the results have been so entirely satisfactory that the method is seldom omitted in cases requiring a careful diagnosis.

There are a number of intra-pelvic conditions which cannot be made out without the use of anæsthesia. Many women have the faculty of fixing the uterus so firmly in the pelvis by contraction of the abdominal muscles as to induce a condition of the intra-pelvic organs simulating the condition found after an intra-pelvic inflammation where fixation has been induced by inflammatory deposits and adhesions. The physical signs indicate complete immobility or restrained movement under an examination by the usual method, but when the patient is anæsthetized perfect mobility will be found.

This is only one of a number of spurious conditions which can be cleared up by the employment of an anæsthetic.

A positive diagnosis in intra-abdominal disease should be given in very few cases until an anæsthetic has been employed to correct errors or to map out minor conditions which cannot be recognized without complete relaxation.

Any surgeon of experience will appreciate the value of anæsthetics as an aid to diagnosis, and it would seem unnecessary to refer to this subject did not the former method of diagnosis prevail to a very large extent. The exaggerated danger of anæsthetics and the discomfort and inconvenience of their employment have largely prevented a more frequent resort to their aid. We think that the results obtained far outweigh the foregoing considerations.

In a most excellent and carefully prepared paper on this subject (*Johns Hopkins Hospital Report*, Vol. III, Nos. 7, 8, 9), Dr. Hunter Robb, of this city, has shown the importance of employing anæsthesia in intra-pelvic gynæcological conditions by reporting an analysis of 240 cases in which the method was employed as an aid to diagnosis and treatment.

Dr. Robb's conclusions are of practical interest in this connection. He says:

1. If a patient presents a history with even a suggestion of pelvic disease a thorough examination should be made as soon as possible.

2. The great majority of gynæcological cases cannot be satisfactorily examined without the aid of an anæsthetic, and if the uterus and its appendages cannot be clearly palpated by the ordinary preliminary examination, then the surgeon should insist on a second and more thorough examination under anæsthesia.

3. Cases exist in which, even with complete anæsthesia, it is impossible to state positively that the structures are free from disease.

4. Anæsthetics which produce anæsthesia lasting only a short time cannot be relied upon in making a thorough examination of the parts.

5. Patients under the method of examination advised will not be subjected to unnecessary operative measures; while on the other hand many women will be restored to health by the early recognition and removal of diseased structures.

We fully endorse Dr. Robb's conclusions, since his views, like our own, have been reached through clinical experience.

In the use of an anæsthetic it will not be found necessary in every case to push the drug to profound anæsthesia. A mere relaxation of muscular contraction can often be secured by a few whiffs of chloroform and thus enable the operator to conduct an examination of his patient with satisfactory results. Where operative measures may be required preparation should be made in advance for the procedure indicated. Such a preparation will not tempt the judicious surgeon to proceed to operate upon a case when the condition ascertained by this method of examination clearly indicates the abandonment of an operative procedure.

We regard the use of anæsthesia not only safe but judicious in the hands of the trained surgeon. In our opinion it will reduce rather than increase the percentage of operative procedures.

AN IMPROVEMENT IN HOSPITAL FACILITIES IN BALTIMORE.

Since the opening of the Johns Hopkins Hospital, with its superb facilities for the care and treatment of disease, and for advanced clinical instruction, the medical schools of this city have recognized the importance of the modern hospital as an adjunct to their clinical work.

The College of Physicians and Surgeons led the way by securing the medical control of the City Hospital, which was constructed with special ref erence to modern methods and details. It presents one of the most admirable hospital plants in this country, having ample capacity for acute medical and surgical cases, to meet all of the needs of the College in its clinical work.

Quite recently, we learn, a movement has been inaugurated by the Medical Department of the University of Maryland looking to the erection of a new hospital on the ground now occupied by the University Hospital.

The sum of sixty thousand dollars has been named as the amount which will be expended in this enterprise.

Plans are now being considered and the movement has taken such a shape that the near future will no doubt witness the erection of a hospital building which will give the University all of the clinical material needed in its educational work. The University Hospital now has a capacity of some 150 beds, with a separate lying-in department, with a capacity of some 30-odd beds. The present building has many advantages in its favor, and has offered clinical instruction for many years to the vast majority of men now in active work in this State and in adjacent States. The erection of a more modern building will be welcomed, however, by the alumni of the school notwithstanding their agreeable recollections of the notable old building and clinical amphitheatre on the corner of Lombard and Greene Streets.

The march of progress is no respecter of sentiment or tradition, hence we say let the old building go and let us welcome the era of new things.

With an energy and progressiveness which are characteristic of the College, we are glad to announce that the Baltimore Medical College will erect during the present summer a new hospital building on Linden Avenue, adjoining the present handsome college building.

The plans of this building have been prepared by the architects, Messrs. Baldwin and Pennington, and have been accepted by the Faculty. The specifications will be placed in the hands of the builders during the coming month, and work will begin by March 15th in order to secure the completion of the building by Oct. 15th.

The plans provide for a handsome brick building, with brownstone trimming, fronting 92 feet on Linden Ave., with a depth of 47 feet, and a wing 69 feet. The building will have a basement and four stories, making practically a five-story structure.

The architects have given special attention to the details with a view of making it perfect in every feature demanded of the modern hospital structure. The plans provide for an expenditure of between $50,000 and $60,000. The building will have a capacity of about 150 beds. When completed the building will be an ornament to the city and a valuable adjunct to the college building erected in 1892. With this new hospital and present college building, the school will have every facility for the thorough education of the medical student.

We have upon a former occasion referred to the remarkable growth of Baltimore as an educational center. With the improvements now in contemplation in successful operation the three leading medical schools of the city will be capable of meeting every requirement in medical instruction as provided by the leading medical schools of this country.

Medical Progress.

TREATMENT OF ALOPECIA AREATA.

Ferraton some time ago showed before the Lyons Societe des Sciences Medicales (*Lyon Med.*, No. 15, 1893) a soldier who had been treated for parasitic alopecia with iodized collodion and who was completely cured in three months. The method consists in applying the substance to the patches after the hair has been cut very close. After three or four ap-

plications, made at intervals of four or five days, it is observed that when the collodion is stripped off some lanugo hairs are brought away it. The patient need be seen only once in four or five days. According to the author the collodion imprisons the parasite and prevents the contamination of neighboring parts and the transmission of the disease to other persons. It excludes the air, and possibly the iodine acts as a parasiticide and as a stimulant of the scalp. Moreover, the collodion acts as an epilatory.—*Brit. Med. Jour.*

SALICYLATES IN THE TREATMENT OF PLEURAL EFFUSIONS.

Dr. George Dock (*Therap. Gaz.*) reviews this subject, and draws the following conclusions:

Salicylic acid and its salts are among the most effectual agents in the treatment of pleurisy with effusion.

2. In effective doses the remedy is harmless, and with proper care in the selection of the preparation and its administration, causes little or no discomfort to the patient.

3. Salicylates act most promptly in pleurisies with serous effusion of recent origin or of long standing, but they are efficient in simple dry pleurisy, and often act favorably in secondary pleurisy.

4. There is no evidence that they are useful in suppurative cases.

5. The drug acts as a diuretic, but may have an effect on the pathological process, or on the cause of the disease.

6. Salicylates have a more marked action on pleurisy than the diuretics commonly so-called.

7. The duration of treatment, with salicylate preparations, is less than with diuretics, common salt or roborant medication.

8. The remedy can be used at the earliest period, and favorably affects all symptoms.

9. The drug may be given in the form of the acid, or any of its salts, in doses of a drachm of the former, or one to two drachms of a salt daily. In ordinary cases it is not necessary to give the large doses; and sixty to ninety grains of sodium salicylate, or of salol, may be considered full-beginning doses, to be diminished one-third, or one-half, if the effect is manifest.

10. The ordinary precautions must be observed in giving the drugs, and during their administration the total amount of urine should be measured daily.—*Memphis Med. Monthly.*

EXTRA-UTERINE PREGNANCY.

Dr. G. Haven, in *Boston Med. and Surg. Jour.*, says: The following symptoms suggest ectopic pregnancy:

1. The absence of menstruation, or a flow coming at irregular intervals, and of uncertain duration.

2. Pain of a severe and spasmodic character, which may be permanent at first, then absent for some weeks, to return later with renewed vigor.

3. Vaginal discoloration—a symptom of some importance, yet often noticed in cases where some other form of pelvic tumor is present.

4. General signs of pregnancy, such as nausea, enlarged and tender breasts, increase in size of the papillæ, darkened aureolæ, milk in the breasts, *ballottement*, the presence of a tumor, irregular menstruation, and, possibly, gait.

5. The history of having had a child

or miscarriage. This is important, as cases occurring in nulliparous women are rare.

6. Expulsion of decidua. This symptom is of great importance, although in the majority of cases we are not fortunate enough to have it present, the clot, and shreds of tissue are thrown away before a microscopical examination can be made.

7. Increase in size of the uterus, with the fundus either pushed forward or to the right or left side.

8. Elongated, soft, and patulous cervix.

9. The appendages on one side containing a thin-walled and tender cyst. The fact, however, that a tumor is felt upon both sides should have no bearing upon the diagnosis, as one of the tumors may be due to extra uterine pregnancy, and the other to some other form of tubal, ovarian or pelvic trouble.

10. Pulsation of vessels in neighborhood of cyst.

11. The rapid increase in the size of the tumor.

12. Presence of fetal heart sounds.

13. Presence of placental bruit.

14. Feeling the small parts of the child, either through the vagina or rectum, or by combined manipulation.

With diagnosis made, the right policy is to operate.

TWO ATTACKS OF SCARLATINA IN THREE MONTHS.

E. F., aged seventeen, was first seen July 21, 1892, when she presented well-marked signs of severe scarlatina, the rash being particularly well developed, the sore throat intense, and the temperature 103.5°. This was the third day of the illness. There were two other cases of scarlatina in younger children in the same room.

I found that she had had a previous attack of scarlet fever, though not of quite so serious a nature, so recently as April of this same year, for which she became an inmate of the Fever Hospital at Stockwell. It was followed by free desquamation; indeed, she had only been discharged three weeks when this second attack occurred. At this time, when questions of immunity and contagion are exciting so much interest, I think it well that a case of so early and severe a recurrence of scarlatina in the same subject should be placed on record. Her mother suffered from puerperal fever at the time of the girl's first attack, and though I did not then see the girl herself, I heard of the case from the medical man in attendance, and was instrumental in removing the mother to the Union Infirmary, where she recovered. Another child in the same house also had scarlet fever then.—Dr. W. J. Barker, in *Brit. Med. Jour.*

A NEW TREATMENT OF MAMMARY ABSCESS.

Tweedy (*Medical Press and Circular*) adopts Weber's method of treating mammary abscess.

An early and free incision is made in the breast, radiating from the nipple, and situated at the most dependent part of the abscess.

The finger is then inserted into the wound and the gland structure broken down. This manipulation, it is stated, will have no bad effect on the healthy tissue.

By this process several new cavities will be found, and these, in turn, are to

be opened by an incision similar to the first, and the whole thoroughly douched with some antiseptic solution.

The membrane lining the several cavities is to be curetted, and the *debris* removed by a second douching.

Strips of gauze sufficient to fill every interstice of the abscess are to be steeped in a one per cent. solution of carbolic acid, and inserted by means of a long sinus forceps and probe. A large, flat sponge is then placed on the breast and tightly bandaged thereto for twenty-four hours. After this period the dressings are removed, and without further irrigation the cavities are again packed, the sponge and bandage being reapplied as before.

On the third day the process is repeated.

In the fourth dressing the gauze packing is dispensed with and the incisions are drawn together and dressed antiseptically; the sponge and bandage are reapplied

This last process is repeated every twenty-four hours until healing is complete; this usually takes place about the tenth day. In one of the author's cases the whole process was accomplished without the aid of anæsthesia. In only one of his cases was it necessary to make a second incision. The incisions are never longer than is necessary to admit a finger.

Iodoform gauze should be used for packing the wounds.

The author only having treated five cases, cannot say definitely what portion of the above treatment is essential, but he is strongly inclined to the opinion that curetting can be safely dispensed with.—*Therap. Gaz.*

STUDY OF THE ACCIDENTS OF VACCINATION.

Engelman offers the following contribution to the study of the accidents of vaccination:

1. Variola is communicable as an airborne and air-exit contagium.

2. Its specific virus has not been isolated.

3. Its identity with vaccinia is undetermined.

The failure and non-protective character of vaccination is due to vitiation of the vaccine supply.

5. This vitiation is (1) saprophytic, annulling the specific quality of the virus, or (2) pathogenic, inflicting injury upon the individual.

6. Consequently such change in the lymph supply is demanded as to exclude a mixed infection.

7. Vaccination confers immunity from smallpox, but not from other (1) synchronous or mixed, or from (2) secondary infections.

8. These secondary contact infections are avoidable.

9. Hence antiseptic methods applied (1) to the present vaccine supply, and (2) to vaccination, will make accidents of vaccination a thing of the past.

10. To procure which end it is desirable, if not necessary, to establish government vaccine stations.—*Med. and Surg. Reporter.*

A MODE OF CONTROLLING THE CIRCULATION THROUGH THE ABDOMINAL AORTA.

Macewen (*Annals of Surgery*, vol. xix, No. 1, p. 1) details a method of controlling the circulation through the abdominal aorta that he has employed for more than fifteen years and found

simple, always ready, easily applied, and efficient. The subject lying on his back, the assistant stands on the left, facing the patient's feet and in a line with the umbilicus. He then places his closed right hand upon the patient's abdomen, a little to the left of the middle line, the knuckles of the index finger just touching the upper border of the umbilicus, so that the whole shut hand will embrace about three inches of the distal extremity of the aorta above its bifurcation. The assistant then stands upon his left foot, over which his right foot is crossed, resting upon the toes, and leans upon his right hand, thereby exercising the necessary amount of pressure. With the index finger of the assistant's left hand the weight necessary for the purpose can easily be estimated by the effect produced upon the flow of blood through the common femoral at the brim of the pelvis. Whenever the flow of blood through the femorals is absolutely arrested the abdominal aorta is sufficiently controlled and no further weight ought to be applied. The pressure exercised can be varied at will by increasing or decreasing the angle that the assistant's body makes with the floor. As the abdominal aorta sometimes bifurcates higher than usual, a trial of the effect of the pressure at the part selected ought to be made before the operation is commenced, testing the result of pressure upon both femorals. When both are equally controlled the bifurcation occurs below the point pressed upon; when only one is controlled the hand requires to be placed on a more proximal part. As there is no direct muscular effort required in maintaining the pressure, further than the preservation of the equilibrium, the position can be maintained by the assistant without undue strain on his part, and without shifting his hand for at least half an hour, a time amply sufficient for the performance of most operations requiring the control of the circulation through the abdominal aorta. Among the conditions in the course of which this procedure has been employed are disarticulations at the hip-joint, amputations at the upper third of the femur, large pelvic vascular tumors, intra-pelvic hæmorrhage, and traumatic hæmorrhage from the external iliacs; in all, the control of the circulation was absolute. In the amputations of the hip none of the patients lost from the proximal side of the cut vessels more than a couple of ounces of blood, and that only from the oozing of the general surface; there was no loss from the main vessels. In amputations, also, after the main vessels were ligated the assistant could, by a slight momentary relaxation of the pressure, "show" the position of any hidden or retractod vessel without altering tne position of thc hand relatively to the aorta. This form of pressure would be equally valuable for uterine hæmorrhage. The pressure is, as a rule, followed by no discomfort. Should violent vomiting or coughing occur in the course of the compression the pressure would have to be increased, as otherwise the abdominal muscles might during the strain elevate the hand from the aorta. In case of vomiting, the operation might be interrupted for a few minutes while local pressure is applied.—*Med. News.*

TREATMENT OF VARICOCELE.

In an article in *The International Journal of Surgery,* Dr. J. W. Handly, writing on the above subject, says:

Dr. Lydston in his monograph on varicocele gives the following indications and contra-indications for the radical operation.

INDICATIONS.

1. When varicocele is very voluminous and a cause of marked deformity.

2. When varicocele is very painful, or is the cause of reflex neuralgia of a severe type.

3. When aberration of the sexual function exist.

When irritation of the scrotum is marked and obstinate.

5. When varicocele interferes with the occupation.

6. When the affected testicle is atrophying.

7. When tbe opposite testicle is diseased.

8. When symptoms of mental aberration are pronounced.

9. When the varicocele is an obstacle to entering public service.

10. When double varicocele exists, and there is danger of serious impairment of the sexual function.

11. When operable hernia or hydrocele exists, and it is desirable to operate on both at once.

12. Rapid increase in size.

CONTRA-INDICATIONS.

a. Coexistence of abdominal tumors.

b. Organic disease of the liver.

c. Heart disease.

d. Recent thrombus.

e. Neighboring inflammation.

f. Epididymitis or disease of the testicle.

g. Advanced hypochondriasis, melancholia, monomania, or other mental disturbances.

A NEW RADICAL OPERATION FOR UMBILICAL HERNIA.

Dr. R. Gersuny, of Vienna, describes the following procedure:

After an incision around the umbilicus (which is usually intimately united with the hernial sac) the sac is separated by blunt means from the fatty tissue and then split. The protruding omentum is ligated, cut away, and the stumps together with any protruding coils of intestine returned to the abdominal cavity. The entire sac is then excised and the peritoneum sutured at the level of the hernial opening, after which the opening is closed by sutures. If the sutures in the peritoneum tear through, the latter together with the hernial aperture should be included in a line of sutures. The sheath of the rectus muscles is then sought for, which is most readily accomplished if the incision is prolonged in a downward direction, parallel with the linea alba, and exposing the recti muscles. Starting from there the sheath of both recti is divided at the median margin of the muscles in an upward direction, and to a point above the level of the umbilicus. The separation of the recti from the umbilicus on each side amounts sometimes to as much as a hand's breath, and to permit of union in the median line the muscles must, therefore, be first rendered sufficiently movable by dissecting off the two inscriptiones tendinea lying in close proximity to each other from the sheath. This stage of the operation always involves the ligation of several arteries. After the muscles have been drawn without marked tension to the median line, their median margins are sutured. Care should be taken to carry the sutures

through the inscriptiones tendinea, since greater firmness can thus be secured than by exclusive suture of the muscular tissue.

The wound remaining in the skin and fatty tissue is of considerable extent, owing to the great length of the cutaneous incision, and to the fact that the fatty layer has to be separated from the fascia over a wide area. Inasmuch as a large wound in fatty tissue is not calculated to heal by first intention, Gersuny in his last series of cases preferred to insert the sutures at once, but not to tie them firmly until the end of a few days, the wound in the meantime being packed with gauze, over which the sutures were tied in a bow-knot.

The abdomen should be firmly compressed with a roller bandage to prevent the tearing of the muscular sutures during coughing or vomiting.—*Wien. Med. Presse.—Int. Jour. Surg.*

TUBERCULIN IN TUBERCULOSIS.

Bey and Kartulis (*Zeitschrift f. Hygiene,* XV, 1893, p. 228) report the results of some very interesting work in the treatment of tuberculosis with tuberculin, together with hygienic and climatic influences. They report 48 cases in which recovery was secured in 16 or 35 per cent. The article is a long one, containing full details of the injections and their reactions, the condition of the patient as determined by physical examination, etc. The results which were obtained, as set forth in the conclusions drawn by the authors, are given:

1. Beginning pulmonary tuberculosis can be cured with tuberculin in from 3 to 4 months.

2. In more advanced cases of phthisis recovery is more slow, six months to a year being required.

3. Severe cases with not large cavities can, under good hygienic conditions, be cured.

4. Very bad cases with large cavities, hectic fever, and night sweats, are not suited to tuberculin treatment.

5. Skin tuberculosis, as scrophuladerma or skin ulcerations, are rapidly healed with tuberculin.

6. Certain forms of bone and joint tuberculosis, also gland tuberculosis, are rapidly cured with tuberculin alone or with the help of surgical interference.

7. Tuberculin is a dangerous material unless it is given in small doses in the beginning.

8. Small doses of tuberculin alone will not produce recovery of tuberculosis.

9. The Egyptian climate is well adapted for the treatmentof tuberculosis.

10. The clinical treatment of lung tuberculosis with tuberculin is indicated only in light cases; in more severe cases the treatment must be more regular and persistent.

The authors lay much stress upon the importance of climate and hygienic influences in bringing about good results. —*Med. and Surg. Reporter.*

TREATMENT OF SURGICAL TUBERCULOSIS BY BOILING WATER.

Dr. Jeaunel, of Toulouse, says:

The action of heat consists in destroying the bacilli tubercles and granulations in the tissues to which it is applied. It decomposes the toxines and destroys the anatomical elements in tissues heated above 80° C. (176°F.). It attenuates the bacillus without killing it, when the temperature is between 42° (109.6 F.) and 80°, but this temperature

is sufficient to destroy the anatomical elements. Below 40° to 42° it attenuates the virulence of the bacillus without affecting the anatomical elements. Heat below 70° requires more than an hour to kill the bacillus. Two methods of applying heat are in use: First, direct cauterization with a hot iron; and, second, the application with boiling water. Hot water affects a larger area than thermo-cautery and penetrates recesses that would not be reached by the latter method. After the wound has been curetted and changed, and the hæmorrhage checked by temporary compression or otherwise, the wound is filled with salt water and a thermo-cautery point is held in this water until it boils. An albuminous foam quickly develops, and the water rapidlyevaporates, but more water should be added from time to time to enable the operator to keep up the boiling temperature for 5 to 10 minutes. In case of a cold abscess which has not been opened, two punctures with trocars, some distance from one another. To one of these trocars a funnel is attached; to the other, a rubber tube. The abscess is then emptied and washed. A coffee pot is then placed over an alcohol or oil stove, and the water allowed to run through the abscess while the heat is so applied that the water is gradually raised to a boiling point. The water escapes through the rubber tube, and complete flushing can be obtained by pinching the tube and stopping the outflow. To protect the skin from burning, it is surrounded by napkins or thick compresses, moistened with cold 1-1000 sublimate solution. In the case of an open wound, after the close of the irrigation, it is tamponed about ten times with anhydrous material, which is carried directly into the wound from a reservoir of boiling salt water. The entire surface assumes the grayish appearance of boiled beef. On removing Esmarch's compression, the wound fills with blood, but a few ligatures are sufficient to control it, and the angles of the incision are closed by suture, and the cavity dressed by aseptic gauze. There is abundant oozing from the wound for from 5 to 8 days, requiring frequent renewals of the dressing, but the wound soon assumes a healthy appearance, and cicatrization is rapid. —*Amer. Med. and Surg. Bulletin.*

Medical Items.

There are 60 mission hospitals in China.

The free church of Scotland sends out no less than 25 medical missionaries.

It is stated that the medical profession of Great Britain has 359 of its members serving the various missionaries, of which number 74 are women.

Professor Milnes Marshall, a prominent English physician, recently met his death from a mountaineering accident at the age of 41.

In London there are now 5,590 qualified physicians, which is equal to one in 750 of the total population, and there is in addition an ever-increasing number of quacks. The outlook of the profession in London is not an encouraging one.

A number of cases of smallpox have occurred during the winter along the line of the Norfolk & Western Railroad in the counties of Page, Warren and the Shenandoah Valley. The disease now is under thorough control.

The four-hundredth anniversary of the birth of the famous Theophrastus Paracelsus von Hohenheim, at one time Professor of Medicine at Basle, was celebrated the 26th of last November by the villagers of his native place, Maria-Einsiedeln in Switzerland.

The Supreme Court of California recently ruled that where the husband is liable for his wife's support, the wife's estate cannot be charged for medical services, medicines and nursing which he secured for her in her last sickness, but that he alone is liable for them.

A town councillor of Burton-on-Trent in England had a narrow escape from burial alive last week. At the very last moment, during the committal service in the cemetery, a friend detected what he thought was a sign of life. On examination the man was found to be still breathing, and was carried home.

Dr. A. R. Mott, a well-known and highly respected physician from Leesburg, Va., died at his residence in that place on January 20th, at the age of 67 years. Dr. Mott served during the late war as surgeon in the C. S. Army. He has practised his profession in Loudon County since the close of the war with great success and popularity.

The *Med. Rec.* states that the dentists of America are the best in the world, but that there is hardly a dentist who works in an aseptic way or uses aseptic instruments. The mouth is a rich culture medium for microbes, and caries is a microbic disease. The American dentists should therefore make the teeth and gums aseptic and prevent caries.

La grippe, which has prevailed in this city during the present month to a considerable extent, is now said to be on a decline. Our physicians who complained of dull times during the fall months have no cause to complain of business during the present month.

A physician in Boston who has been vaccinating the employees of some of the large hotels reports that he was able to vaccinate 48 white persons an hour, but only 38 negroes in the same time. As all the other conditions were the same, the greater thickness of the black man's skin suggested itself as the explanation. —*Boston Med. and Surg. Jour.*

The medical profession of Syracuse, N. Y., has dropped the name of the City Medical Association, and reorganized under the name of the Syracuse Academy of Medicine. The Academy has obtained new quarters and opened new library and reading rooms. A legacy of $500 from one of its deceased members is to form a nucleus of the library. The entire profession of the city have joined the new organization with the avowed purpose of making it a success.

Dr. P. L. Kean, of Wooster, Ohio, was recently indicted for failing to take out a license from the State Board of Dental Examiners. The case being called in court, motion was made to quash the

indictment on the ground that the act requiring dentists to register specially exempted the practice of dentistry by physicians. The court sustained the motion and the defendant was discharged.

At a meeting of the Faculty of the Medical Department of Columbian University, of Washington, D. C., held on April 11, 1893, it was unanimously agreed to make a four-year course of study necessary before graduation. This measure went into operation at the beginning of the present session of 1893-94. Each of the four courses covers seven months of lectures.—*Boston Med. and Surg. Jour.*

The *Medical Record* states that the number of suicides has increased from 241 in 1892, to 313 in 1893. This increase is attributed to the hard times. San Francisco is placed in the lead, where 7 out of every 20,000 kill themselves annually. New York comes next, and Philadelphia and Boston show a very much lower rate of percentage. In Central Europe it is stated that one out of every 4,000 kill themselves, while in New England only one out of 25,000 will do it.

The President has appointed Dr. Stephen Smith, of New York, Dr. Edward O. Shakespeare, of Philadelphia, and Dr. Preston H. Bailhache, of the Marine Hospital Service, as delegates to the approaching Paris conference regarding the international relations of Asiatic cholera. This movement is under the auspices of the French Government, and is spoken of as the International Sanitary Commission of 1894. Each of the great powers of the civilized world has received an invitation to be represented by three delegates. The first session was held on January 24th.

Again we say to physicians: *Write your prescription in plain English.* If you are fresh from the classics, write them in Latin, if you must. In any event let them be legible! Misinterpreted directions are sometimes serious in the outcome and sometimes ludicrous. We recently came upon the following: The label upon the medicine gave the directions as follows—"Gargle a whole, and drink a half teaspoonful every four hours." The writing of the physician was at fault and was misapprehended. The intention was that George should take a whole and David a half teaspoonful every four hours—referring to the respective doses to be taken by two members of the same family.—*North Amer. Practitioner.*

At the annual meeting of the Baltimore Medical and Surgical Society, held January 25, 1894, the following officers were elected for the ensuing year: President, Dr. John D. Blake; 1st Vice-President, Dr. Thos. A. Ashby; 2nd Vice President, Dr. H. T. Reynolds; Cor. Sec'y, Dr. Stephen Crowe; Rec. and Reporting Sec'y, Dr. J. B. Bates; Treasurer, Dr. A. T. Shertzer; Executive Committee: Dr. F. C. Bressler, Dr. Wilmer Brinton, Dr. R. W. Mansfield; Committee on Lectures: Dr. J. F. Spicknall, Dr. R. G. Davis, Dr. T. C. Gilchrist. Committee on Honor: Dr. J. F. Martenet, Dr. David Streett, Dr. J. F. McShane. The annual banquet, which was held at the close of the meeting, was largely attended by the members. The occasion was one of the most enjoyable in the history of the Society.

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Original Articles.

REPORT OF TWO CASES OF GASTRIC ULCER.*

BY R. H. P. ELLIS, M. D.,

Professor of Materia Medica and Therapeutics, Baltimore Medical College.

I beg to begin what I have to say to-night by stating that so short a time has elapsed since I was requested to have something to say on this occasion, that it has been quite impossible for me to do more than treat the subject announced in a most superficial way.

To begin at the beginning, I may say that during the last eighteen months I have treated at least two cases of what I believe to have been gastric ulcer of a severe type, but as both of my patients finally recovered, I had no opportunity to verify my diagnosis by a post-mortem investigation.

And while I congratulate myself and my patients upon this happy result, I feel quite sure that we both owe much to our ever-present and faithful friend, vis medicatrix naturæ. But while I fully appreciate the great importance of the powers of nature toward bringing about a spontaneous recovery in all curable maladies, and that without this vital aid in connection with the healing art, our best efforts would so often be of no avail, nevertheless I feel quite sure we can do much in a strictly scientific and artificial way to materially assist her in her efforts.

Certainly it is true that one of the most important functions of the physician in his administrations upon the sick is never to handicap nature at any

*Read before the Baltimore Medical Association, Oct. 23rd, 1893.

point. It is of the greatest importance that not only the right thing should be done in the right way and at the right time, but that the wrong thing should never be done. It is quite as important to know what not to do as what to do. And this is as true in connection with the treatment of disease as in other lines of conduct. But as I have no intention to be elaborate in my remarks at this time, I beg to submit a very brief mention of the two cases already referred to.

Miss W., aged 22 years, occupation that of stitching uppers in a shoe factory, sitting at a machine run by steam eight hours daily. She had suffered much during the early months of 1892 from an acid form of indigestion and failure of appetite.

During the first week of April she had several chills of an irregular type and much nausea and gastric distress after taking food, for the relief of which she consulted me. I ordered small doses of calomel and soda bicarbonate to relieve the nausea and constipation present and this was to be followed by three-grain doses of quinine sulphate every three hours.

Two days later I was sent for to visit her at her home, and found that the calomel had produced the desired cathartic effect, but the quinine had been retained in the stomach but a very short time after each dose was taken. Bismuth, liquor calcis and mint water, given at short intervals, failed to afford relief from the nausea.

I continued this line of treatment for three or four days, making use of such drugs as bismuth, hydrocyanic acid, ingluvin and oxalate of cerium, together with counter-irritation over the epigastrium, but the symptoms of severe gastric irritability became progressivly more pronounced, and on the fourth day after my first visit I was sent for in great haste.

I found, as stated by the messenger, that she had vomited a large quantity of blood and was greatly frightened and prostrated in consequence thereof.

Lumps of ice were directed to be swallowed at frequent intervals, heat applied to extremities, 1-6 grain of morphia sulphate was given hypodermically, and perfect quiet enjoined. Later in the day she had revived somewhat, but was restless and much disposed to vomit. One-fourth grain of morphine hypodermically gave some relief and rest during the night. The treatment for several succeeding days consisted of the free administration of ice to allay nausea and restrain hæmorrhage.

For two days nutritive enemata were exclusively depended upon for nourishing the body. After this milk and liquor calcis, and, later, milk and precipitated magnesium hydrate (Phillips' milk of magnesia) was given in small quantities as food, alternated with small amounts of light beef broth and gruel.

For the purpose of neutralizing the hyperacidity present in such cases, this preparation is certainly far superior to the alkalies in more common use. It is less irritating and gives rise to no evolution of carbon acid gas in the stomach. In appearance and taste it closely resembles cow's milk, with which it mixes readily.

On the sixth day after the first hæmorrhage, another occurred more severe than the first, and I saw her before it had ceased.

She seemed verily to be in articulo mortis. Pulse imperceptible, extremities

cold and bathed in perspiration, breathing slow, shallow and sighing. Heat was applied to extremities, and a hypodermic syringeful of brandy containing one-sixth of a grain of morphine was promptly made use of, and as soon as she could swallow, lumps of ice again given.

All stomach medication was abandoned and this organ left entirely alone in so far as the giving of medicine was concerned, except the use of Phillips' solution of hydrated magnesia with milk to correct the excessive acidity present. Many forms of food were made use of, such as beef tea, beef broth, gruel, peptonized milk, malted milk and buttermilk. The last mentioned proved very acceptable on many occasions. Later in the history of this case the white of egg in warm water with a small amount of brandy seemed of benefit. After the acute stage had passed hot milk sipped from time to time seemed to be more readily appropriated than when given cold. During the early part of convalescence pepsin and hydrochloric acid were given with food, and, later, tr. ferri. chlor. A solution of the peptonate of iron was given for a while and was agreeable to taste and it was well borne.

This patient made a fair recovery in about four months and has been engaged at her same occupation since about that time, but her digestion has on several occasions since her illness shown evidence of failure, and at this time she is somewhat anæmic.

My second case was that of Mrs. B., married and mother of two children. Previous history showed no serious illness, except occasional attacks of intermittent fever.

For two or three months prior to my first visit she had suffered much from an acid form of dyspepsia, and had lost so much flesh that her friends thought she was going in decline. She had some cough, which served to give some plausibility to such an opinion from an objective point of view.

At the time of my first visit, she was somewhat jaundiced, was much nauseated and inclined to frequent vomiting.

She had had a chill on each day for three days previous to my visit. One-sixth of a grain of calomel every hour gave no relief; bismuth with hydrocyanic acid, and liquor calcis, produced no better results. A chill occurred on the following day and quinine given by the stomach was promptly ejected. I then used a solution of the hydrobromate of quinine hypodermically, which speedily put an end to the chills and other evidences of malarial toxæmia.

To accomplish this result the quinine was used daily for perhaps two weeks. Persistent vomiting in spite of the use of such remedial measures as enumerated in connection with my first case, and the pain and tenderness over the epigastrium, together with the presence of blood in matter vomited, which in this case, however, was very small in amount, made it plain that I had someting more than an ordinary case of intermittent fever to deal with.

Gastric irritability and intolerance of food continued with great and alarming persistency for about five weeks, during which time little or no medicine was given per orem.

The one and only remedy that gave relief from pain and vomiting was mor-

phine hypodermically. Usually one-quarter of a grain was used morning and night, but I sought to avoid the morning dose when possible. It invariably afforded such complete rest and comfort that it seemed to me cruel to refuse its use, even at the risk of establishing a habit. Neither patient ever knew positively that it was morphine that I gave her, and no craving for it was manifested in either case after convalescence was established.

The same line of feeding as mentioned in connection with the first case was adopted, but my patient became greatly emaciated, and hope of her recovery was pretty well abandoned by all parties except myself, and I confess that mine was not of a very lively character, since each day for about four weeks seemed to show only a progressive failure in her powers of assimilation.

But there came a time when the food taken remained longer in the stomach, and the disposition to vomit became less frequent.

Slowly convalescence became an established fact, and in about three and a half months she had regained a sufficient degree of health to enable her to attend to her ordinary household duties.

Seven months have now elapsed since her recovery and she has enjoyed a fair degree of health during that time. She has regained flesh to a degree somewhat in excess of that enjoyed before the first indication of her illness, and no symptoms of her old enemy, malaria, have ever reappeared.

In each of the cases mentioned the menstrual flow ceased; in the first case for five, and in the second case four months, and then reappeared.

Now as to the ætiology of gastric ulcer, I do no propose here to speak, except to say that in the first mentioned case, a sedentary occupation and the daily lack of sufficient fresh air and sunlight probably had much to do in establishing a condition of anæmia favorable to the occurrence of gastric ulcer.

The hygienic environment of the second case was good and could not be reasonably charged with having had anything in particular to do with causing the disease.

The previous history of each case showed several months of slowly failing health, with more or less persistent dyspepsia. The second case had undoubted intermittent fever when first seen.

Now I feel sure it will be observed that I have suggested no new or startling idea in connection with my management of gastric ulcer, for my treatment consisted very largely, and I may say essentially, in letting the organ affected severely alone.

But I conceive this letting the stomach alone, and, in every way possible, securing the most complete physiological rest of that organ, to be the strongest point in the treatment. And for this purpose I believe that the judicious use of morphine hypodermically, especially at night, is the most important and useful drug at our command.

No one particular form of food will be found to agree well for many consecutive days, but frequent change from one to another, paying attention to the likes and dislikes of the patient, is the plan I believe likely to prove most useful in the long run.

Ice cream sometimes agrees well for a time, but patients are apt to soon tire of

it. I have now, at the time of this writing, what promises to be the most severe case of gastric ulcer, or possibly malignant disease of the stomach, I have ever seen, in which I have been using ice cream, but after three days' trial the patient, a lady in this case also, developed a disgust for it.

Pure cow's milk, in one form or another, is undoubtedly one of the most generally useful foods, but to obtain the best results from it, after all danger of recurring hæmorrhage has passed, it is often best taken hot and in small quantities at stated intervals. During the early days of convalescence in such cases, the circulation is so feeble, and the nutritive processes so depressed, that it becomes of vast and vital importance that the vital forces of the patient be sustained. And when the ability of the stomach to absorb is so slight, and remembering that food put in the stomach cold must be raised in temperature before it can be either digested or absorbed, the importance of such food being previously heated is at once appreciated. It is a well-known fact in therapeutics that in many asthenic conditions, and especially in the collapse following severe hæmorrhage, nothing that we can do for our patient will prove of greater service than the administration of hot milk, for the reason that it is rapidly absorbed and enters the circulation far more readily than when given cold.

For the same reason, most medicines made use of in such conditions, such as ammonia, brandy, etc., will be found more prompt and efficient in their action when given warm.

In an experience of fifteen years I have attended several cases believed to be gastric ulcer, and in only one case did I make use of lavage, partly because of the popular prejudice against that form of treatment and the difficulty of carrying it out in private practice, and partly because of its doubtful utility in acute diseases of the stomach.

In conclusion, I would say that when we know we have a gastric ulcer to deal with, in my opinion the best mode of treatment is to abstain from giving any medicine per orem so long as vomiting is a prominent symptom, leaving the stomach to exert what power it possesses of digestion and absorption, upon the light liquid foods given to sustain life.

I have many times attempted to nourish patients by nutritive enemata, but the bowel so soon becomes intolerant of such infringment upon its rights, that only very temporary benefit resulted.

In both cases recited, morphine in the stomach failed to give relief, but, hypodermically, certainly proved of the greatest benefit, and no craving for it was present after convalescence was established.

I am inclined to the opinion that there is far greater danger of establishing a habit or desire for its effects, when it is used to relieve such pain as ordinary ovarian, or sciatic neuralgia, or rheumatism, than in those pathological states where the nutrition is far below the normal.

In these latter cases, if it be used with care and withdrawn at the earliest possible moment as convalescence sets in, no harm is likely to result, the patient, under such circumstances, being progressively less likely to feel the want of the drug as nutrition improves and general vitality increases.

733 W. Fayette Street.

Special Abstracts.

ATONY OF THE STOMACH.

In the *Medical News* of December 23, 1893, Dr. Julius Friedenwald, of this city, has contributed an article on this subject.

Atony of the stomach is that condition in which the muscular walls have lost their tonicity, with a resultant motor insufficiency, in consequence of which the stomach is unable to pass its contents into the intestine at the normal rate.

Atony may be of two kinds—primary and secondary. Primary atony is found in persons who have been in the habit of consuming large quantities of indigestible food; the excessive use of fluids especially predisposes to this disorder; frequently, however, no such cause is assignable. Atony may be secondary to many other diseases, such as those of the brain and cord, typhoid fever, anemia, tuberculosis, and diseases of the gastro-intestinal tract, such as gastroptosis, chronic gastritis, enteroptosis and nervous dyspepsia.

As to symptoms, most patients complain of a loss of appetite, though in rare instances the appetite may be fully maintained, at least in the first stages. When the condition is secondary to nervous disorders the appetite may even be increased (Peyer). A feeling of pressure or fulness comes on, usually during or after meals, and this is especially marked after the ingestion of fluids. This feeling of pressure is accompanied by heartburn, pyrosis, eructations of gas, and, rarely, by vomiting. The quality as well as the quantity of the food ingested is productive of the symptom; fluids are most likely to induce pressure. Constipation is almost a constant symprom, and headache of a dull character is frequently present, and may at times lead to actual vertigo. Nervous symptoms of various kinds may be present, such as palpitation of the heart and indefinite pains, and on this account the disorder is frequently mistaken for neurasthenia.

On physical examination the stomach is found to be enlarged, so that the greater curvature reaches to, or below, the level of the umbilicus. Peristaltic and anti-peristaltic movements of the walls of the stomach may occasionally become visible. With but small quantities of fluid in the stomach (from 250 to 300 c. c.) a splashing sound may be produced by quick movements of the patient, or by a series of quick shocks with the fingers upon the abdomen. The boundary of the greater curvature of the stomach may be determined by marking the limit of this splashing, and sometimes when the stomach is dislocated downward, the lesser curvature also. The boundary of the greater curvature may likewise be located by percussion; especially is the method of Dehio to be recommended: he allows a quarter of a liter of water to be swallowed, and the position of the greater curvature obtained by the limit of flatness against the tympanitic transverse colon; by drinking more water the curvature sinks until it reaches the umbilicus. In normal conditions it does not reach beyond this line. In atony, however, with but little fluid it sinks quickly below this limit.

Still more reliable is the method by expansion of the stomach with gas,

which may be accomplished by the old method of Frerichs. Carbon-dioxid gas is produced by the ingestion of a teaspoonful of sodium bicarbonate dissolved in a small quantity of water, followed quickly by the ingestion of the same quantity of tartaric acid in water. But it is simpler and better to introduce air into the stomach through the stomach-tube by means of an ordinary double bulb of a spray apparatus. On percussion the stomach will be found to reach to, or below, the umbilicus.

In atony, the stomach is not only enlarged, but its motor function is also markedly impaired; and it does not propel its food into the intestine at the normal rate. The propulsive force of the stomach may be measured by the salol test of Ewald and Sievers. Fifteen grains of salol are swallowed during a meal, and the urine is tested for salicyluric acid at half-hour intervals, beginning one-half hour thereafter, and continuing until the response occurs. Usually salicyluric acid appears in the urine in from forty to sixty minutes after ingestion.

In patients suffering with enfeebled motor activity of the stomach, as in cases of atony or gastrectasia, the reaction lasts much longer. Of greater value is the test-dinner of Leube, consisting of a plate of soup (400 c.c.,) scraped beef (60 grams), a piece of white bread (50 grams), and a glass of water (200 c. c.). Under normal conditions the stomach will be found empty in from six to seven hours. Should particles of food be still present after this time the motor function of the stomach is much impaired.

A most important test is the condition of the stomach before the ingestion of food (Boas). If the contents of the stomach be expressed in the morning before the ingestion of food, the stomach will be found entirely empty and free of all food remains. This is not so in cases of gastrectasia, in which greater or smaller quantities of food will be found. Boas has devised still another test, which I have found of great service. The test supper of Boas consists of white bread with butter, cold meat, and a large cup of tea. In atonic conditions the stomach will be empty the next morning, but in gastrectasia it still contains food-remains at that time.

The examination of the gastric contents is of great importance. The expression one hour after an Ewald test-breakfast shows large quantities of solid contents, not separating into the characteristic three-layered fluid of gastrectasia, or containing yeast-spores or sarcinæ.

Upon chemic examination the contents show in most cases a normal proportion of hydrochloric acid, pepsin and casein ferments. According to Boas, at the very beginning of atony of the stomach, through constant mechanic irritation of the food upon the walls of the stomach, an increased acid production results; in fact the irritation may be so great that even hypersecretion may be produced. A case of this kind has come under my observation. In other cases there may be a condition of subacidity.

Among the frequent complications of atony may be mentioned dislocation of the stomach (gastroptosis) and also of the bowel (enteroptosis) and dislocation of the right kidney.

Atony of the intestine is not an infrequent concomitant of atony of the stomach—indeed, both may be present

for years, and it may be difficult to tell which is the primary trouble.

Gastric vertigo, the vertigo dyspeptica of Trousseau, which this writer believed to be caused by chronic gastritis, probably depends in most cases upon atony.

Atony of the stomach must be differentiated from nervous dyspepsia and gastrectasia (or dilatation).

The variability and rapid change of symptoms, the presence of other nervous symptoms, the normal and increased appetite, and the absence and rapid disappearance of the gastric disturbance, distinguish nervous dyspepsia from atony.

From gastrectasia, atony is diagnosticated by the absence of food-remains from the stomach in the morning before the ingestion of food; by the absence of the three-layered fluid of gastrectasia, and by the absence of sarcinæ and yeast-spores. There is a marked diminution in the secretion of urine in gastrectasia, but not in atony.

The treatment of myasthenia depends in general upon its cause. If it is secondary, the treatment must be directed to the primary disorder. The dietetic treatment is highly important. It is necessary that the quantity of fluid taken shall be very small. According to Boas not more than from one to one and a half liters of fluid should be taken daily, though in general larger quantities of milk are contra-indicated; in some cases this food is well borne and proves serviceable. The examination of the acidity of the gastric contents gives us indications for the regulation of the diet. If superacidity exists a meat-diet in general is indicated. To this can be added soft-boiled eggs, with but few vegetables. Butter should be allowed in small quantities. In cases of subacidity the more digestible forms of meat should be allowed in small quantities. The vegetable diet may be increased in these cases.

In the treatment of the chronic constipation which accompanies most of these cases, my experience coincides with that of Boas. The use of cathartics is in most cases to be deprecated. The method to be carried out is the proper regulation of the diet. Such substances are given as foods to stimulate the peristalsis of the intestine; for this purpose, Graham bread, fruits and vegetables are ordered in rather large quantities; to these is added milk-sugar, which may be used twice daily in teaspoonful doses to sweeten coffee or milk, and which thus acts as a purgative.

In other cases of constipation, when the treatment just described proves ineffectual, injections of various kinds may prove beneficial. Lavage of the stomach should not be practised in this condition.

Of greater benefit is the use of the stomach-douche, especially in those cases depending upon the various gastric neuroses. Still more beneficial is the use of electricity, which may be applied either extra-ventricularly or intra-ventricularly by means of Einhorn's electrode. The best results are obtained by the intra-ventricular method. The tonicity of the muscular walls of the stomach are influenced by the faradic current. Painful conditions are alleviated by the galvanic current, the kathode being used intra-ventricularly, the anode placed upon the fundus of the stomach. To

this may be added massage of the abdomen, the effect of which is to increase the peristalsis of the intestine and to strengthen the abdominal walls.

In regard to the medicinal treatment, preparations of strychnin seem to serve the best purpose. Either strychnin sulfate or the extract of nux vomica may be given in pill-form. To allay the feeling of pressure, which is a constant and annoying symptom, the extract of belladonna may be prescribed. When there is a diminished secretion of hydrochloric acid, fifteen-drop doses of dilute hydrochoric acid, given, according to the method of Ewald, several times after meals, is indicated.

Selected Articles.

THE PRESENCE AND ABSENCE OF FREE HYDROCHLORIC ACID IN THE STOMACH.*

BY H. SALZER, M. D.

By the phloroglucin-vanillin test we are able to detect the faintest trace of hydrochloric acid in the expressed contents of the stomach. The absence of this test, however, does not mean that the stomach does not secrete the acid; the test is only for free acid. The acid, which has become absorbed by albuminoids and in the formation of neutral salts, and is present in the stomach contents, is not shown by the test; still it was secreted and did its work. The search for these compounds is laboratory work, and for the practitioner it is sufficient to know that in the normal healthy stomach at the height of digestion, and in the empty stomach after mechanical irritation, there is free hydrochloric acid, varying in amount from $\frac{1}{2}$ to 2 per mille. All investigations have verified this. We consider the height of digestion an hour after the Ewald test-breakfast, or three hours after a more complex dinner.

As regards the quantity of acid present, there are many methods, more or less detailed and cumbersome. Still, by some practice it is not difficult to determine quite accurately and quickly the amount by the Guenzberg test. Some, as Einhorn, prepare different dilutions of the stomach contents and draw conclusions from the intensity of the reaction. I have found that by using a titration method, the modification of the red tint is sufficient to make precise estimates as to quantity. The differences in color acquired by using exactly the same amount of reagent and of hydrochloric acid, diluted to a certain degree, will show you the practical value of this.

In the specimens shown here I have used hydrochloric acid diluted to $\frac{1}{5000}$, $\frac{1}{2000}$, $\frac{1}{500}$, and $\frac{1}{200}$, equal to $\frac{2}{10}$, $\frac{5}{10}$, 2, and 5 per mille; you see the clear differences of the respective proportions. Compared with this, even the simplest methods—as Leo's with carbonate of lime—are of little value to the busy practitioner. I proceed as follows: Put three drops of the Guenzberg reagent and six drops of the stomach contents in a flat porcelain dish—the ordinary butter-plate answers the purpose admirably—and let the reagent and stomach contents mix thoroughly, then place the dish about a foot above a Bunsen flame turned low, and let the mixture evaporate. This takes from ten to fifteen minutes, during which time the attention can be devoted fully to other work.

*From Johns Hopkins Hospital Bulletin, Dec., 1893. Read before the Johns Hopkins Hospital Medical Society, December 18th, 1893.

The fact that the healthy stomach contains free hydrochloric acid would indicate that the absence of acid *per se* expresses pathological conditions. But the diagnostic value of this for cancer and atrophy of the tubules has been considerably modified. According to all authors, in non-compensated heart disease this symptom is quite frequently present.

In my own experience, referring mostly to alterations in digestion, I have found free hydrochloric acid absent in almost one-third of the cases examined. The ease and accuracy of the test exclude every error in this direction. The majority of the patients had comparatively good digestive powers, and the pepsin and rennet functions were more or less normal, but present. Most of them, however, showed an abnormal amount of lactic acid, respectively the corresponding reaction with Uffelman's test. Normally, this reaction is present only in the beginning of digestion, and decreases towards the height of digestion as the hydrochloric acid increases.

The presence of free hydrochloric acid in the empty stomach, without mechanical irritation, is abnormal, as well as an amount of the same exceeding the normal quantity, at the height of digestion, and often reaching from 5 to 7 per mille. Both these conditions, the hyperchlorhydrie proper, often simply called hyperacidity of the stomach, are frequently observed without any pathological changes, and are then, according to all authorities, considered purely neurotic in origin; of the pathological conditions the peptic ulcer is most frequently met in connection with hyperacidity.

Achlorhydrie—absence of free hydrochloric acid—is frequently to be looked upon as the result of grave circulatory disturbances, especially of those connected with overloading the venous system. This statement, of course, does not comprise cancer and atrophy. It would appear but natural that hyperchlorhydrie, the opposite condition, should be due to the opposite cause, that is, arterial hyperæmia. I have analyzed my cases of this year from this standpoint, as shown in this table. I shall substitute for achlorhydrie, euchlorhydrie, and hyperchlorhydrie, the more common expressions, anacidity, normal acidity, and hyperacidity. It is readily understood that they do not refer to acidity in general, but only to free hydrochloric acid, its absence and its presence in normal or surplus quantities.

TOTAL: 120 PATIENTS; 364 EXPRESSIONS OF STOMACH CONTENTS.

Achlorhydrie: 44 Cases; 139 Examinations.

Essential chronic gastritis, 3.
Chronic gastritis and dilatation, 3.
Chronic gastritis, dilatation and atrophy, 2.
Chronic gastritis, valvular heart disease, 3.
Chronic gastritis, dilated (fatty) heart, 7.
Chronic gastritis, cirrhosis of liver, 3.
Chronic gastritis, parenchym, nephritis, 2.
Chronic gastritis, interstit. nephritis, 1.
Chronic gastritis, malaria, 1.
Chronic gastritis, leukæmia, 1.
Chronic gastritis, tabes dors, 2.
Chronic gastritis, gallstones, 2.
Carcinoma of stomach, 1.
Carcinoma with atrophy of tubules, 3.
Leube's nervous dyspepsia, 5.

Hæmaturia, 1.
Carcinoma pelvis, 1.
Carcinoma of kidney, 1.
Epilepsy, 1.
Catarrh. antri. Highmor, 1.

NORMAL CHLORHYDRIE: 33 Cases; 112 Examinations.

Essential chronic gastritis, 7.
Essential chronic gastritis and dilatation, 1.
Chronic gastritis, spleen tumor, anæmia, 1.
Chronic gastritis, valvular heart disease, 1.
Chronic gastritis, dilated (fatty) heart, 1.
Chronic gastritis, cirrhosis of liver, 1.
Chronic gastritis, floating kidney, 1.
Chronic gastritis, intestitial nephritis, 1.
Crisis gastriques, tabes dorsalis, 1.
Chronic gastritis, gallstones, 2.
Nervous dyspepsia, neurasthenia, 2.
Nervous dyspepsia, floating kidney, 3.
Nervous dyspepsia, hysteria, 4.
Peptic ulcer, 3.
Peptic ulcer, phthisis pulmon., 2.
Lead poisoning cardialgia, 1.
Pyelitis, 1.

ACHLORHYDRIE ALTERNATING WITH CHLORHYDRIE: 18 Cases; 60 Examinations.

Essential chronic gastritis, 6.
Chronic gastritis, dilatation, 3.
Chronic gastritis, dilated (fatty) heart, 1.
Chronic gastritis, parenchym. nephritis, 2.
Chronic gastritis, interstitial nephritis, 1.
Nervous dyspepsia, neurasthenia, 3.
Nervous dyspepsia, hysteria, 2.

HYPERCHLORHYDRIE: 25 Cases; 53 Examinations.

Chronic gastritis, valvular heart disease, 1.
Chronic gastritis, dilated (fatty) heart and sciatica, 1.
Chronic gastritis, interstitial nephritis, 3.
Nervous dyspepsia, neurasthenia, 3.
Nervous dyspepsia, hysteria, 7,
Nervous dyspepsia, floating kidney, 1.
Peptic ulcer, 6.

The table comprises only those cases of which I was able to keep records, and enumerates 120 patients with 366 examinations of the stomach contents. While the majority had from two to five examinations, some had as high as 15 and 20. In these 120 cases were 44 cases of anacidity, entire absence of free hydrochloric acid, of which only three were cancer, and only five showed no pepsin or rennet reaction, that is, atrophy of the gastric tubules.

Thirty-nine patients had more or less good digestion despite entire absence of free hydrochloric acid for a long time. Among the patients with valvular disease there is one case of hyperacidity, one with normal acidity, and three with anacidity. Cases with eccentric heart-hypertrophy, resp. dilatation—the majority being probably fatty heart—are comparatively numerous. They are mostly habitual over-eaters with sedentary occupations, and seldom are without dyspeptic symptoms. Of these cases I have one with hyperacidity, one with normal acidity, and seven with anacidity. In parenchymatous nephritis two showed no acid and two normal acidity, while of those with interstitial nephritis with hypertrophy of the left heart I have only one with anacidity and three with hyperacidity.

It is an established fact that nervous dyspepsia and peptic ulcer predispose to hyperacidity. Allow me to remark that a majority of these patients show a nervous heart function. I have nevertheless cases of hysteria and neurasthenia—

Leube's nervous dyspepsia—which did not react for hydrochloric acid, and I have one case of dilated heart, impulse not palpable, and one with vitium cordis not compensated, which showed decided hyperacidity. The great majority of the cases, however, seem to sustain the view expressed above, that an overloaded venous system favors absence of free hydrochloric acid, and an arterial hyperæmia tends to produce a surplus of its amount.

I have here the histories of three cases showing absence of free hydrochloric acid for months. This continued even when there was perfect digestion, and the cases showed free acid only after the circulation had been greatly improved. This was accomplished by an entirely changed mode of life. There is also one case of nephritis with no free acid, which after months showed free acid present, at the same time that the left heart began to hypertrophy. Moreover, three cases of interstitial nephritis with hypertrophy of the left heart showed hyperacidity, despite the absence of any symptom pointing to peptic ulcer. This is very striking, as one would expect just the reverse in such severe lesions. Of course in the latest stages of nephritis this may be different. I have not had an opportunity to investigate this point.

The histories are as follows:

J. W. P., a man, æt. 32, clerk.

January 7.—Patient had been examined two years before and found very dyspeptic. He had slight albuminuria and hyaline casts, and had then complained of being weak, of fulness and pain after eating, bad taste in the mouth, and eructations.

Examination showed the lungs healthy; the heart impulse was weak; the arteries good. Urine showed trace of albumen; sp. gr. 1026; no casts, many urates and indican. A test-meal showed impaired digestion, pepsin and rennet present, but no free hydrochloric acid. The latter was not found, either after test-meals or in the empty stomach, until October—that is, 10 months later. By this time his general condition was much improved, though he complains now a good deal of burning on an empty stomach. There was no albumen in the urine, and no casts were seen. The heart impulse was now comparatively strong. The patient had spent the summer in the country and had led a wholesome life.

C. W. S., a man æt. 31, traveling agent.

January 13.—The patient had complained for years of depression and dyspepsia, and gave the history of sexual neurasthenia. The examination was entireiy negative, except that for three months there was no free hydrochloric acid in the stomach contents. Pepsin and rennet ferment were almost always present in normal proportions. The patient stopped his irregular life and regulated everything—habits, food and exercise. He lived exclusively in the country. His pallid appearance soon gave way to a normal fresh one. Until August—8 months after coming under observation—the stomach showed varying degrees of acidity, from none to hyperacidity. In the last two months the patient has improved, despite temporary nervous spells, and every examination shows free hydrochloric acid.

Mrs. J. R., a woman æt. 40, a singer,

June 16.—Complained of rheumatic and neuralgic pains at different parts of the body; she was easily fatigued and out of breath.

Examination showed lungs normal; heart was dilated, the first sound quite weak; it was evidently a fatty heart. Urine, sp. gr. 1021, showed indican, a trace of albumen and many urates. Expressed stomach contents after a test-meal showed a low digestion, reacted for pepsin and rennet ferment, though slowly, and showed no free hydrochloric acid. Four weeks later there was still no acid, but the pepsin and rennet reactions were much better, and digestion was normal. Under constant hygienic measures the circulation improved immensely; the symptoms disappeared, and after four months free acid appeared in the stomach contents.

A. H. S., a man, æt. 56, a merchant.

January 12.—Patient had lues when young; of late had much dyspepsia, sick headache and vertigo.

Examination showed lungs and heart normal, arteries sclerotic. Urine, sp. gr. 1007; polyuria—there was ¼ to 1 per cent. of albumen, and hyaline and granular casts were seen. Repeated stomach examinations showed varying pepsin and rennet reaction, but no free hydrochloric acid. This was in 16 examinations in 8 months. The acid then appeared, and in October and November there was 1 to 3 per mille of acid present. At the same time the heart showed physical signs of commencing hypertrophy of left ventricle.

The urine still shows all the signs of interstitial nephritis.

We consider alterations in the kidney as due to both circulatory and parenchymatous causes and refer them to the primary affection. Now, in the stomach the influence of the locality is quite evident. It is almost certain that the glands of the fundus with the parietal cells (Belegzellen) secrete the muriatic acid; the glands at the pyloric portion appear to have nothing to do with this. The blood-supply of the fundus from the gastro-epiploics is very free, and it is probable that the blood-distribution is an important factor.

There is an analogy between the spastic urination and the hyperacidity of hysterical patients. This urination, as well as that appearing in the chill of malaria, have been thought to be more than neurotic. They are probably also the result of arterial hyperæmia. I think this explanation may also be applied to the hyperacidity in contrast to the lack of acidity being related to venous congestion.

I would refer you to the causal relation chlorosis so frequently bears to peptic ulcer, and to the great increase of the heart's action in the latter disease. Although it is chiefly the right heart that undergoes eccentric dilatation, still there is almost always a strong impulse visible on the left side, pointing to increased action of the left ventricle.

There have been innumerable theories to account for the formation of peptic ulcer. Pavy suggested lack of alkalies in the blood to neutralize the hydrochloric acid; V. Sohlern referred to the want of potash salts. Shiff and Ebstein have shown that an incision into the anterior corpora quadrigemina is followed by necrotic processes. Other theories are that of proliferation of cells (Virchow), degenerations of arteries, result-

ing at times in miliary aneurisms (Welch), capillary hæmorrhagic infarcts, trauma, too hot and too cold ingesta, chemical and mechanical irritation, as too coarse food or foreign bodies. Bacterial invasion has been pointed out by Klebs, Boettcher and others. It has been shown that no one of these causes acts alone to produce the ulcer; they merely lower the *vis resistentiæ* of the part, which is then eroded by the hydrochloric acid; and in an exhaustive search of the literature of the subject I have not found any allusion to the difference in venous and arterial pressure —although Ewald refers to the rare combination of peptic ulcer and hepatic cirrhosis, despite the intense hyperæmia (he does not say venous hyperæmia)—yet it seems to me this difference in pressure must be of great importance. I would call your attention to the well-known fact that when the lungs are laden with venous blood there is a great tendency to cirrhosis, chronic inflammation, œdema, etc., but very little tendency to phthisis. This last named is a comparatively rare complication of valvular heart disease. Indeed, an experienced practitioner will make a diagnosis of a burst, dilated vein from the dark venous blood coughed or spit up by a cirrhotic potator; on the other hand, a stream of bright red blood points to phthisis in hæmoptosis, and to peptic ulcer in hæmatemesis.

I am well aware that the difference between active and passive congestion does not depend solely upon an increased or decreased action of the left ventricle, but on the condition of the entire circulatory apparatus, and that for instance we may have hyperacidity despite a weak left heart, though most probably it is even here due to arterial hyperæmia caused by nervous influences.

In general, I believe that the fact that there is absence or decrease of acidity in venous congestion, and hyperacidity in arterial hyperæmia, is well enough established to be of diagnostic and even therapeutic value. For instance, in cases where complete anæmia (as cancer and atrophy) is excluded, we should think of venous congestion and an overloaded right heart as a possible cause of decreased acidity, and similarly in hyperacidity we should look for an over active left ventricle. In the absence of acid, stimulationof the circulation is indicated, while in hyperacidity we should give sedatives. The success of the strict rest treatment in peptic ulcer seems to me to favor this view.

Of course there are cases of hyperacidity where outdoor exercise is advisable, and again cases of subacidity which require rest. It is well known that a non compensating and overworked heart needs rest and not exercise, but even here the rest may be looked upon as a stimulus for the weak heart.

Finally, I wish to repeat that decrease and absence of acidity is often identical with venous and hyperacidity with arterial hyperæmia. This, and more especially the unexpected frequency of the absence of free hydrochloric acid in the stomach, are the object of this paper.

Dr. E. H. King says that atropine will as certainly dilate the os uteri as it will the iris. Dose, 1-100 grain hypodermically; a second dose is hardly necessary.—*Nat. Med. Rev.*

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BALTIMORE, FEBRUARY 10, 1894.

Editorial.

CIRCUMCISION FOR THE CORRECTION OF SEXUAL CRIMES AMONG THE NEGRO RACE.

A great deal has been said and written upon the question of rape by the negro in the South.

The brutal and uncontrollable passion of the negro has been traced to a variety of causes, the chief of which has been referred to a perversion of his sexual instincts and ungoverned sexual passion.

The treatment for this peculiar crime has been, so far, extremely radical. The individual has, with rare exceptions, paid for his lust by accepting violent forms of death. Lynching and other forms of torture have shown no tendency to check the criminal practices of this unfortunate class.

Among the remedies proposed legal castration has had very warm advocates. It is quite doubtful whether this method could be made to reach any large number of cases, nor is it probable that a law could be enforced with any degree of justice or humanity that would prove practicable or efficient.

A recent suggestion has been made by Dr. P. C. Remondino, in the *National Popular Review* (January, 1894), which throws some light on this question and is, at least, worthy of consideration. Dr. Remondino is a well-known student and writer on the subject of circumcision. He has made researches into the origin and practice of this religious rite by the Jewish and other races, and has studied its influences from a physical, moral and religious standpoint. He has observed that whilst male Jews are noted for their strong sexual proclivities, such a character as a Jewish rapist is never heard of. He attributes this fact to the practice of circumcision and he now suggests that the legal enforcement of circumcision among the negro race would effectually remedy the predisposition to raping inherent in this race.

He says: "We have seen this act as a valuable preventive measure in cases where an inordinate and unreasoning as well as morbid carnal desire threatened physical shipwreck; if in such cases the morbid appetite has been removed, or at least brought within manageable and natural bounds, we cannot see why it should not—at least in a certain beneficial degree—also affect the moral stamina of a race proverbial for the leathery consistency, inordinate redundancy, generous sebaceousness and general mental suggestiveness and hypnotizing influence of an unnecessary and rape, murder and lynching breeding prepuce. It would

certainly be more humane for a State Legislature to pass an act legalizing and enforcing circumcision as a preventive measure, just as it would enforce either vaccination or quarantine regulations, than to enact laws to castrate or eunuchise the accused after his infraction of the law."

The male negro child, he claims, is subject to many nervous disorders from slight irritation. This characteristic follows him through life. An enlarged prepuce is assigned as a most frequent cause of irritation and its removal, he believes, will lead to the stopping of sexual crimes and to the moral improvement of the race.

There is much good sense in this suggestion, as there is much good sense in the practice of circumcision among neurotic male children of the white race. The general adoption of circumcision as a legal measure for any class would, no doubt, meet with violent opposition. It seems practicable, however, to secure much success in this direction from the co-operation of the medical profession. If circumcision was more frequently advised and practised as a hygienic and preventive measure in selected cases, we feel assured much good would result to society from such a measure. Such suggestions are entitled to careful reflection and consideration.

THE CELEBRATION OF THE 75TH ANNIVERSARY OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

Our medical brethren of Washington propose to celebrate the 75th anniversary of the Medical Society of the District on the evening of Feb. 16th. The programme provides for a number of addresses by prominent members at the National Rifles Armory Hall, to be followed later by a banquet, at which a "feast of reason and flow of soul" will add to the importance and enjoyment of the occasion.

Whilst this Medical Society has passed three-score years and ten and has reached the age of retirement, it continues to show the vigor and energy of youth in its work and progressiveness. This Society has done a great service for the profession of the District and its organization and influence have been felt in many ways upon the professional standard of Washington.

The proposed celebration is a proper recognition of the influence of the work of organization, and will prove a healthful stimulus to the future development of this work. It is eminently fitting that medical men should come together in this way and commemorate their progress in useful achievements and in influential measures which have exercised a wise control over professional interests. The membership of this Society will profit by such exercises, and the Society itself will grow in authority and respect, as well as in the esteem and affection of its members.

The profession in every locality, too, should value such influences for good, and should regard their local and State organizations as institutions which educate and broaden the medical mind and strengthen those ethical relations which are necessary to the larger growth and prosperity of scientific medicine.

The profession of our own city and State will within a few years be able to

celebrate the one-hundreth anniversary of the organization of the Medical and Chirurgical Faculty of Maryland. We suggest now that this matter be kept in view, and that we begin at once to inaugurate plans which will result in such a commemoration of that occasion as will awaken the pride and loyalty of the profession in our State in the work of the Faculty as has not been experienced in the past.

This event should be celebrated by dedicating a new hall and a new library in keeping with the honor, dignity and usefulness of the profession of this State and as a just recognition of our esteem and love for the old Faculty.

TOO MANY PROFESSORS.

The *Medical Record*, of New York, and the *Medical and Surgical Reporter*, of Philadelphia, have been exchanging some pleasantries in regard to the excess of "professors" in their respective cities. New York seems to have a surplus and proposes to send a few over to Philadelphia. The *Reporter* begs the "Angels and Ministers of Grace to defend" its city against such an importation, as Philadelphia has now more of this class than it can safely care for. It says:

"Indeed, it looks as though "professors" would soon require a congressional appropriation (either under a River and Harbor bill, or a deficiency appropriation) to secure an opportunity for letting men see their light shine. "Professors" are too numerous and chairs cost too much, and we don't want them anyhow, but for higher medical education and the progress of medicine, we do want more efficient *teachers*, and we wish to see them paid for the value of their brain-work and not for ability to make excerpts from the ancient chronicles of medicine."

As Baltimore is becoming with rapid strides the great medical educational centre of this continent, it is probable that room can be made here for more "professors" from our sister cities. The importation so far has brought us a number of men who reflect credit upon our city, and we are prepared to extend a hand of welcome to a few more, if they will measure up to the standard of those now here. We must protest, however, against being made a dumping ground for those who "require a congressional appropriation to secure an opportunity for letting men see their light shine."

THE PERMANGANATE OF POTASH AS AN ANTIDOTE FOR MORPHIA.

It has been known for some time that morphia can be rendered inert by the permanganate of potash. A practical test has been made by a young Austrian physician, Dr. Wm. Moor, of New York. Dr. Moor recently swallowed three grains of the sulphate of morphia in solution and immediately afterwards he drank a solution of four grains of the permanganate of potash in four ounces of water. No bad effects were experienced from the poisonous dose taken. Dr. Moor had prevously experimented with rabbits and also on his own person, beginning with an eighth of a grain, and then a quarter, and then half and finally three-quarters of a grain. He claims that he is perfectly willing to take six grains instead

of three, insisting, however, that the antidote must be administered as promptly as possible after the morphia is taken. After the morphia has been absorbed the permanganate can have no action upon it, hence in cases of poison by morphia or opium in any of its forms it is necessary to administer the permanganate immediately.

Dr. Moor is now engaged in making a series of experiments to test the powers of the permanganate as an antidote against strychnia, cocaine and other poisons. The permanganate has been used as an antidote for serpent's poison. It seems to destroy the constitution of such poisons when brought in direct contact with them, but when introduced in the general system does not control their action. Whilst the drug has a limited application in cases of poison it is well to bear in mind its value in such cases.

Medical Progress.

DANGER OF TRIVIAL WOUNDS.

It is obvious that many lives are lost each year in consequence of the lack of common sense respecting simple cuts or wounds of the hands or other parts. Cases are often seen recorded in the press, of inquests relating to persons who have died from blood poisoning arising from slight wounds or injuries of the hands.

The history of all these cases is practically the same. A man working at his trade receives a small cut on the hand. The trivial nature of the injury is such that it scarcely calls for notice; the small wound is left, so to speak, to take care of itself, during which time, in the majority of cases, it is exposed to all kinds of filth and sources of infection. If nothing happens under such circumstances, and the wound heals, the result is due to good luck rather than to good management.

But we should do well to remember that the most trivial wound of the skin is liable to be followed by acute septicæmia, and may result fatally. It is in such cases as these that "prevention is better than cure." By thorough cleanliness the tendency of wounds to become infected can be effectually prevented; on the other hand, once let the septic process become inaugurated, and the surgeon is, as a rule, unable to do anything to stem its virulence.

Carelessness, perhaps, more than ignorance, is the cause of most people neglecting these trivial skin wounds, and it becomes the duty of the surgeon to educate those whom his words may influence in this respect, and teach them that as long as a wound, however insignificant, remains unhealed, there is a risk of blood poisoning setting in with its train of attendant miseries. "Cleanliness is next to godliness," and nowhere is this more apparent than in surgical practice; and nowhere else is the truth of the adage better exemplified.—*Canada Lancet.*

COMPARATIVE INFLUENCE OF LARGE AND SMALL DOSES OF IRON.

The comparative effects of large and small doses of iron and the indications for the one or the other are discussed in the *Therapeutic Gazette.* The experience of the writer in treating twelve cases of anemia, which were as far as possible alike, confirmed his belief in the small

doses. Six of these people received two or three grains of reduced iron three times a day, and the remaining six received one-third of a grain three times daily. The six that received the small doses had far less disorder of digestion than those who received the large doses. They recovered as promptly as those receiving the large doses, if not more so. It is true that in some conditions in which there is gastro-intestinal disorder associated with the formation of gas arising from fermentation or decomposition, and in which the anemia is largely due to the destruction of the constituents of the blood by the absorption of poisonous materials from the intestine, large doses of iron are absolutely necessary, because in these instances only a small quantity of iron is absorbed, and the greater amount of it forms a sulphide of iron, or other compound, with the contents of the intestine. Where we have, therefore, a destruction of the iron in large amount, it may be necessary to give it in full dose; but unless this be the case, one-eighth of a grain of reduced iron will in most cases give better results than three grains. Under these circumstances constipation more rarely occurs, and we also avoid in this way the so-called iron headache.—*Ex.*

THE RELATIVE FREQUENCY OF FIBROID PROCESSES IN THE DARK-SKINNED RACES.

In an article in the *Medical News*, Jan. 27th, 1894, Dr. Edward A. Balloch says:

I think that sufficient proof has been adduced to show that we have, in the frequency of these fibroid processes in dark races, a distinct racial peculiarity.

If the premises here laid down be correct, the following conclusions may legitimately be drawn:

First. The dark-skinned races differ from the white race anatomically, physiologically, and pathologically.

Second. That there are three diseases characteristically frequent in the dark-skinned races, as shown by the independent testimony of English, French and American observers. These are elephantiasis Arabum, keloid, and the so-called uterine myomata.

Third. That these are all mesoblastic growths, and that in general terms their essential characteristic may be said to be an increased development of fibrous tissue due to proliferation of cells around the capillaries, these being increased in number and size, and having thickened tunicæ advantitiæ. They are true inflammatory scleroses.

Fourth. That in respect to malignant growths, the same connective tissue type predominates.

Fifth. That it may be laid down as a pathologic law, not heretofore enunciated, that there is some peculiarity in the dark-skinned races rendering them liable to growths of a fibrous nature in a degree greatly exceeding that observed in the white race.

STATE CARE FOR EPILEPTICS.

Dr. J. B. Maxwell read a paper on this subject before the Illinois State Medical Society in which he quotes from a report by Dr. Frederick Peterson, of the colony at Bulefield, Hanover, Germany, as follows:

"For nobility of conception and for excellence of result, it is unique in our civilization. It seemed to its benevolent founder that it was possible to create a refuge where such sufferers

could be cured, if curable; where their disease might be ameliorated and their intellectual decay prevented; where they might find a comfortable home if recovery were impossible; where they might develop their mental faculties to the utmost; might acquire trades or engage in any occupation they saw fit to choose, finally to grow into a community of educated, useful, industrious, prosperous, and contented citizens. There has been a complete realization of his project. There has been a gradual evolution and expansion of the colony, until now it has over one thousand inhabitants. When I visited it in 1887 it consisted of fifty-five houses and cottages, scattered in pretty gardens over some three hundred and twenty acres of beautiful woodland and meadow. It was like a country village. Here schools are to be found in which instruction is given in all branches usually taught in ordinary public schools, and opportunities are afforded for even higher studies in the languages, arts and sciences for those who desire them. Here are stores and shops of many kinds, such as a seed store, grocery, drug store, joinery, bakery, tailor shop, paint shop, blacksmith shop, foundry, tin shop, shoe shop, saddlery, dairy, brick yard, printing office and bookbindery.

"Floriculture, agriculture and fruit raising require large numbers of epileptic employes. Some of the houses have been planned by epileptic architects, the brick made by sixty epileptic patients at the brick-kiln, the masonry done by epileptic workmen, the woodwork made by their carpenters, the iron work by their own smiths, the painting, glazing and furnishing by their own adepts in these various trades. For men alone, there are over thirty different callings. The women are busy with the manifold cares of the household, manufacture of wearing and bed linen, and the raising of flowers and garden produce. Thus it will be seen how nobly philanthropic has been the conception and carrying out of this project. And it is not only in the multiplicity of occupations that the genius of its conceiver has been made manifest, but also in all those vocations that tend to divert the minds of the patients from the contemplation of their misfortune. Games and amusements are many; out-of-door sports; evening entertainments; singing schools, a museum, etc.—all have been thought out for the perfect evolution of this little social world."

PHYSIOLOGICAL ACTION OF PILOCARPINE.

Dr. D. W. Prentiss, of Washington, has a reprint of an article of his, read before the New York Academy of Medicine by invitation. The paper gives a very exhaustive study of the physiological action and therapeutic uses of pilocarpine. The part of the paper to which we call attention, however, is that which relates to the effects of this drug in changing the color of the hair. Dr. Prentiss exhibited to the Society specimens of hair before and after using this drug. In the case reported the hair was light blonde with a yellow tinge. Twelve days after beginning the hyperdermic use of the drug the hair was noticed to be darker, and from that time the change of color was rapid, until two months later it was black. The hair also became coarser and thicker in its growth, the eyebrows and eyelashes, before almost invisible, came out beautifully penciled. So far as the author

knows this is the only drug which, taken internally, is capable of changing the color of the hair.

Dr. Prentiss also calls attention to the fact that Cayenne pepper will change the color of canary birds to orange. The change of color in parrots from green to yellow or red is brought about by feeding the fat of a certain kind of fish. The restoration of certain birds to their original brilliant colors has been done by feeding a kind of shrimp. The author concludes by saying that it is within the bounds of possibilities that discoveries may be made in the future by which the color of the hair in the human race may be modified by judicious treatment of the parents.—*Food.*

Recommendations of Therapeutic Agents.

LORETIN, A NEW ANTISEPTIC.

Professor Schinzinger, of Freiburg, Baden, writes:

In a pamphlet on "Iodoform Treatment," I published in 1883 the results of my experience with iodoform and was able to report many successful cases, as for instance a case of empyema of the pleural cavity and of a purulent cystitis, which were cured by a single treatment with a strong iodoform emulsion. At the same time I had also to complain of toxic effects. As large doses were avoided these latter cases became less frequent.

Two drawbacks to the use of iodoform can, however, never be avoided: the frequent appearance of an artificial eczema and the objectionable odor, which completely destroys the appetite of many of my patients and also of the nursing staff. I therefore accepted with pleasure the offer of Professor Claus to try in my private surgical clinic a new substitute for iodoform prepared by him. The new preparation bears the scientific name of meta-iodo ortho-oxyquinoline-ana-sulphonic acid. For the sake of simplicity it is given the more convenient commercial name Loretin. It is, as its chemical name declares, an iodine preparation. Loretin forms a beautiful yellow crystalline powder, which immediately reminds one of iodoform in appearance, but which is completely odorless. In water and in alcohol it is only soluble to a slight extent. In ether and in oils it is practically insoluble, but on the other hand it forms with oily liquids and especially with collodion emulsions which are excellently adapted for many purposes. Loretin powder is equally well adapted, especially when mixed with a small proportion of calcined magnesia, as a dusting powder for the surface of wounds and for insufflating into hollows and cavities.

The non-poisonous character of Loretin has been established by careful experiment, and I need not therefore enter into this point here; I also abstain from a detailed description of bacteriological experiments which have likewise been carried out in the Freiburg laboratory by Dr. Ammelburg and will be published in full on a future occasion.

In my operations I have employed as few instruments and hands as possible. The carbolic spray I have never used, nor the copious sluicing of the part operated upon with carbolic or corrosive sublimate solutions, which frequently make the surgery appear more like a slaughter-house than a professional cabinate. During the operation the surface of the wound is kept clean with dry sterilized

pads of gauze and then closed with the needle. A bandage with lumps of surgical wadding and Loretin collodion is then laid upon the closed wound; cavities are dusted with Loretin powder or a tampon of Loretin gauze is introduced; in punctured wounds a small pencil of Loretin is laid. The healing of the wounds is usually unaccompanied by any fever and progresses without festering. The absolute absence of any irritant effect upon the skin is a very important advantage in Loretin. Artificial erythema or eczema I have never yet observed caused by it, but on the other hand very persistent eczema has been cured by Loretin.

Medical Items.

After an exciting contest, Dr. Murdoch Cameron has been appointed to the vacant chair of midwifery in the University of Glasgow, formerly held by Prof. Leishman. Dr. Berry Hart was a strong competitor for the position. It is claimed that British politics had a hand in the selection. Dr. Murdoch is, however, regarded as fully worthy of the honor conferred on him.

At the last meeting of the State Board of Medical Examiners of the State of Washington, held in Seattle, there were twenty one applicants for a license to practise, of whom twelve failed to pass the required examination and were rejected. The Board now requires a general average of 75 per cent. on all branches, a rise from its former standard, and soon the standand will be raised to 80 per cent.

Mathews' Medical Quarterly is the title of a new journal, which appears for the first time in January of the present year. The journal is devoted to diseases of the rectum, gastro-intestinal diseases and rectal and gastro-intestinal surgery. The first number is filled with a most excellent class of original articles from well-known specialists and gives evidence of a high standard of work in a field which has not been over-cultivated. The journal is edited by Dr. Jos. M. Mathews, with Dr. H. E. Tully as associate editor. It is published in Lonisville. Its mechanical make-up is most attractive. The subscription price is $2.00 per annum. To one working in this special field the journal will be found of great value.

The National Medical Review. February, 1894, publishes a most excellent portrait and sketch of Dr. S. C. Busey, of Washington, D. C., which is a just compliment to a most genial gentleman and cultured physician. Dr. Busey has filled many positions of honor in his profession and has won the love and respect of the profession by his high-toned standard of work and conservative position as an author, teacher and successful practitioner. The Medical Society of the District of Columbia has recently elected Dr. Busey as its presiding officer for the second time. To be esteemed and rewarded by the local profession in this manner is an honor of which any physician should feel proud. In the case of Dr. Busey, the Medical Society of the District honors itself by this judicious selection of its president during the year in which it is to celebrate its 75th anniversary.

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Original Articles.

A PLEA FOR THE EARLY TREATMENT IN EAR DISEASES.*

BY EDWARD J. BERNSTEIN, M. D.,

OF BALTIMORE.

Those of us who are engaged in the treatment of ear disease see, only too often, the dire results of "non-meddlesome surgery" in this branch of our art, so that we must perforce conclude that the general practitioner either does not know how to treat these troubles in their early stages or neglects them entirely.

For my own part, I am convinced that the greatest fault lies with our medical schools in that there is little or no stress laid upon its study. That an organ whose pathological state is so inimical to life, and whose physiological functioning is of such great pleasure, not to say benefit, should be so ruthlessly slighted is deplorable in the extreme. How much more deplorable is it when we know that in most cases the results, instead of leading to grave operations, often with loss of hearing, might have ended in certain restitution had intelligent attention been directed to the ear, in the acute stages of disease.

If it required a great many costly instruments or if the intelligent use of the few things required long and constant practice, as in the case of the ophthalmoscope, one might be inclined to leniency. But when the most important instruments are a bit of rubber tubing, a small speculum, and possibly

*Read before the Semi-Annual Meeting of the Medical and Chirurgical Faculty, Nov. 22, 1893.

a small augular knife, the whole outfit not costing more than a dollar or two, what can be said?

Fortunately for a certain percentage of these cases, and very, very unfortunately for another very large percentage, some of these patients do get well by the kind powers of restitution of nature. This fact is known and so we trust to luck that the case in hand will also end favorably, thus shifting the responsibility from our shoulders.

I know the impression prevails very largely among medical men that "we can do nothing in ear diseases," and "if you can not get an ear well by syringing you may as well give it up for a bad job." How many of us hear patients tell us that the "doctor said I would grow out of it;" and also "if the discharge were stopped it would go inward." These notions are permitted to exist till the case runs on into mastoid troubles.

What is essential is that you who have the opportunity for such infinite good should watch your cases of exanthemata more closely, and upon the slightest approach of ear symptoms apply the proper remedy.

As to furunculosis. Of course most of us have used the knife where we have seen actual pointing. This is as it should be. But where the inflammation is more general I doubt if you have done much good by making one or two *slight* nicks in the skin. Hot medicated solutions of morphia sulphate, gr. iv–℥ii, or atrophia sulphate, gr. i to ℥i of water, or ext.opii aquasi, 1 to 3, poured into the ear, where no perforation exists, are excellent remedies. If there be much fever, tr. aconite in two-drop doses, repeated every two hours, can be given.

Dr. Theobald has recommended pyrophosphate of soda in from x–xx gr. doses every two hours.

Prof. Gruber, of Vienna, uses his amygdalæ opii—small pearl-shaped gelatine suppositories, containing ½ gr. of opium each, which are placed in the meatus and allowed to dissolve. I can testify to the great good resulting from their use in a number of instances.

Prof. Politzer uses liquor borovi, made as follows:

℞.—Alum acet.	.	1 | 0
Plumbi acet.	. .	5 | 0
Aquæ destil.	.	100 | 0

Saturate cotton with this solution and make cold poultices over the whole ear.

Where pain is excessive, *deep* scarification in front of the tragus and encouragement of the bleeding acts wonderfully. Let me add a word of protest against the use of leeches for this purpose, as instances of poisoning from their bites are well-known.

Where scarification has failed, or even before, application of ice water through thin rubber tubing coiled about the ear, or still more desirable, the apparatus of Leiter, is a great boon.

Painting the inside of the meatus with a solution of one part carbolic acid to thirty of glycerine—one may add extract of opium in proportion of 1-30—is highly extolled.

This makes an excellent application even after opening the furuncles; in fact, I always use it.

Now, above all, do not syringe these ears, for you will only add to the mischief; and do not use the popular sweet oil and laudanum. Oleaginous mixtures tend to production of mycoses.

Where the trouble lies deeper and in-

flammation of the tympanum and tympanic cavity are in question, the ice water application through the tubing is, or should be, the very first thing thought of; its utility may be augmented by the application of an ointment like the following, rubbed over the mastoid.

℞.—Ext. Opii
Ext. belladonna. · āā 1 part.
Lanoline. . . } āā 10 parts.
Ung. Hydrarg. }

Five or six drops of 5 per cent. solution of cocaine passed through the Eustachian tube by means of the catheter is also very valuable. As a dernier resort, paracentesis of the drum remains, but one should only use this when convinced that less radical measures will not avail, for this is always followed by suppuration, which of course lengthens the treatment.

It is, however, infinitely better to make the opening yourself than to trust to nature doing it for you. In the former case, healing with full restitution almost always follows in a few days, while in the latter there is almost no end to the difficulties started.

Prof. Urbanschitch, of Vienna, recommends inhalation of pearls of nitrite of amyl till coughing sets in, or one sees increased injection of the malleal blood vessel.

There is an axiom in general surgery that such a thing as "idiopathic peritonitis" is an utter impossibility. If diligent search were made a focus would always be found. I am not so sure that the same can not be said of meningitis, and just how large a percentage of the many deaths from meningitis annually reported might have resulted in restitution had rational treatment or inspection of the ears been instituted must remain an open question. And just how many children might have escaped deaf-mutism from extension of inflammatory middle ear affections to the labyrinth had early treatment been inaugurated I leave those of you to judge who have read Mr. Love's article on deaf-mutism in the July number of the *Archives of Otology*.

What can be done when all of these means have either been neglected or have failed to respond and the case is now chronic? I venture to say nothing reflects greater credit on the modern aurist than these very cases. I will illustrate this by the following cases, which owe their chronicity to four various causes.

Case I.—Miss W., æt. 22, consulted me, by the advice of her physician, for a left otorrhœa, which followed an attack of measles six years ago. The discharge had been stopped for various periods, only to recur on the slightest provocation. Discharge now present for two months, quite offensive; more profuse at night and should she happen to lie on left side, the pillow is stained. Perforation large, involving the whole membrana flacceda, or Schrapnell's cavity. Has no adenoids; nose and pharynx normal.

Thorough cleaning with the syringe through Hartman's canula soon decreased the discharge and the slight amount remaining was not in the least offensive, as healing did not progress satisfactorily. The ear was cocainized and the attic was thoroughly curetted, bringing out large quantities of cholecysteatomatous masses. Subsequent thorough cleaning through the canula and packing with Gruber's iodoform gauze pledgets

brought the case to a happy end in a few weeks.

Case II.—Willie H., 13 years old, had chronic otorrhœa, both sides, for two years after an attack of scarlet fever. Both tympani soggy and dull-looking; small pin-hole perforations in posterior inferior quadrants, through which offensive matter was discharging. Deciding that healing could not be brought about with so little chance for escape of pus, I determined to perform paracentesis to allow free escape of pent-up pus, after which cleaning out middle ear with a normal solution of salt, through the catheter, and perfect cleansing from the external meatus.

Syringing the ear with a solution of boric acid cured the patient in four weeks.

Case III.—Nathan A., 12 years old, chronic otorrhœa in both ears since his third year, following an attack of scarlatina. Tympani soggy and dull-looking. Perforations in the posterior inferior quadrant about 1½ m.m. (each) in diameter. Discharge whitish and flaky, not especially offensive. Patient is a "mouth-breather" and has the typical adenoid face. Posterior rhinoscopy settled the diagnosis positively. The vegetations were removed by Gottstein's curette. The nares cleaned daily. Catheterization and syringing the ear with boric acid solution cured my patient and when discharged, his hearing, which had gone down to distinguishing whispered syllables at three metres, soon rose so that he now hears whispered sounds and sentences at six metres.

Case IV.—Mr. Gilbert ——, æt. 32, has had chronic otorrhœa for 20 years, attended by a great deal of itching in external meatus, and a good deal of sanio-purulent fluid from right ear; left normal. Right ear large heart-shaped perforation involving whole lower segment of tympanum, tips of malleus hanging free. Upper portion of drum covered with epithelial scales.

The foramen ovale and the grooves on promontory could be plainly seen; the rest of posterior surface of middle ear was covered with granulations which bled on slightest touch. After a thorough cleansing, the parts were cocainized with powdered cocaine and then curetted. Bleeding was controlled by pledgets of cotton soaked in hot water. After again washing out the ear with boric acid solution, aristol powder was blown in and the cavity closed with iodoform gauze. The patient has been rid of his otorrhœa since.

I purposely avoided going into the pathology and biology of suppurative ear trouble before a body of practical men, and tried to bring again before your notice the many devices known to our art for the cure of ear diseases.

You will see by this that we are more fertile of resources than the syringe, powerful as that is, for good.

I have also not said anything about the graver operations: of opening the mastoid cells, cleaning out the lateral sinus in the skull cavity, etc.

In conclusion, let me add that I hope the day is not far distant when all medical schools shall insist on more clinical experience with this organ before sending out their graduates, and see that they, at any rate, when they leave them, know what to do when they have to deal with such cases.

800 Madison Ave.

TUMORS OF THE SUPERIOR MAXILLARY.

BY J. H. BRANHAM, M. D.,
OF BALTIMORE.

The intention of this paper is not to present a complete treatise on superior maxillary tumors, but simply to relate the histories of two interesting cases operated on by me during the past summer at the City Hospital, and to discuss briefly some of the more important points suggested by these and similar cases, especially with reference to treatment.

Case I.—Peter King, age 29, colored, male, laborer. Admitted to City Hospital June 22nd, 1893. History: nine years ago the left half of his inferior maxilla was removed by the late Professor A. J. Coskery, for sarcoma; about three years ago an epilus was removed from his left superior maxilla by Professor C. F. Bevan. The patient says that the present growth has been coming about two years. No history of injury or of heredity. Examination showed considerable bulging forward of left side of face and projection of molar bone and part of superior maxilla upward, so as to close, partially, the left eye. The left hard palate was very much depressed and projecting backward behind the posterior palatine arch was a large soft tumor which largely filled the left side of the pharynx. The clinical diagnosis of sarcoma of the superior maxilla was made. Excision was advised and readily consented to by the patient.

Operation June 28th, 1893. The face and neck having been shaved and made clean by soap, water, permanganate of potassium and bichloride of mercury, the patient was given chloroform and a preliminary tracheotomy was done; the pharynx was cleansed and packed with absorbent cotton. The Ferguson incision from the front of the ear underneath the orbit and down the side of the nose where it joins the face, and down the middle of the lip, was then made. Hæmorrhage was considerable but was readily controlled by Péan forceps. The cheek was next separated from the bone. The bony attachment of the left superior maxilla was next rapidly cut through with large bone pliers, and this bone, with the left palate bone, removed. It was now found that the pterygoid processes of the sphenoid were involved in the growth which projected backward and these were cut through high up at their junction with this bone and removed. It was discovered that the tumor projected downward toward the glenoid cavity and in removing this part the hæmorrhage was excessive. As soon as the operation was completed, the hæmorrhage was easily controlled by pressure.

The posterior attachments of the tumor were separated by scissors and the curette was applied to the deeper parts of the cavity after the operation. The cavity was now packed with sterilized gauze, the skin wound was closed by continuous sutures, after which a sterilized gauze dressing was applied.

The tracheotomy tube was removed on the second day, but the wound remained open for about a week. The packing was removed from the cavity on the seventh day; the foul odor which is so disagreeable in these cases being overcome to a great extent by a two per cent. solution of permanganate of potassium.

The temperature was never higher

than 102°. The skin wound healed by first intention, the large cavity left by the operation rapidly filled by granulation and the patient made an uninterrupted recovery. He was discharged July 28th, entirely well and strong.

Case II.—Hannah McKenzie, white, female, age 40, American, widow. Admitted to City Hospital August 26th, 1893. History: Struck on side of the head by a shuttle about a year ago. About four months ago first noticed a swelling on right side of face, which seven weeks ago broke into the nose and mouth and discharged a very offensive matter. This discharge has been repeated every two or three days since. The patient suffered great pain and has been using anodynes freely.

Present condition: Patient is very anæmic and weak. Projecting from the right maxilla underneath the skin by the cheek is a soft pulsating tumor which almost closes the right eye; over this, skin is tense and reddish. The mass presses well down into the mouth and closes the right side of the nose.

Operation August 28th, 1893. Incision same as in the preceding case. The tumor was found to have destroyed almost entirely the superior maxilla. This, with the palate and part of the ethnoid, were removed and the cavity thoroughly curetted. The posterior part of the orbit extensively invaded. The patient took the anæsthetic (chloroform) badly, and was given several injections of strychnia and digitalis during the operation. She rallied slowly after the operation and was very weak for several days. The hæmorrhage, although not excessive, was severe, when the patient's weakened condition is considered. The skin wound healed by first intention; she improved rapidly after the first few days, and was able to be about in two weeks, but complained of great pain in the eye, for which reason she was kept in the hospital.

The pain in right eye and swelling of the lid remained and were troublesome.

September 20th the pain in eye had increased so as to require anodynes. During the last part of October the patient became irritable, and then comatose, and finally died on November 1st, two months and three days after the operation.

It was impossible to get a post-mortem, but death undoubtedly resulted from extension to the cranial cavity. These tumors were kindly examined by Professor Keirle and are both spindle-cell sarcoma.

Butlin* says that the larger portion of malignant tumors of the upper jaw appear to be carcinoma, usually squamous; while Joseph D. Bryant† in the histories of 250 cases gives 71 sarcoma to 47 carcinoma.

This would indicate that sarcoma occur more frequently, the giant cell being the most common variety.

Treatment: The early diagnosis and treatment of these tumors are of the greatest importance, as the thorough removal in the first stages gives the only hope for these poor sufferers.

Partial excision is comparatively a safe operation, but is apt to be followed by recurrence and should be employed only when the tumor can be entirely removed by it, and even then the pa-

*"The Operative Treatment of Malignant Disease," London, 1887, p 128.

†Transactions of the Medical Society of the State of New York, 1890, p. 63.

tient should be carefully watched for recurrence.

Dangers: The complete removal of the superior maxilla has, according to Butlin, a mortality of 30 per cent. This conclusion is from the study of 108 cases—42 from the various London hospitals, and 66 from German reports.

Bryant (l. c.) reports 183 cases with 26 deaths, or 15½ per cent. The sources of his statistics are not given, but they are up to a date three years later than Butlin's and probably contain many American cases.

Tracheotomy. The question of preliminary tracheotomy is very important. It enables the operator to select the most convenient position for the patient, and undoubtedly increases the ease with which the tumor can be studied and manipulated. On the other hand, the operation of tracheotomy in itself adds something to the danger, and I think it probably increases the liability to septic pneumonia, from the passage from the pharynx into the bronchii, of substances. This would naturally be the case, as the ability to expel such foreign bodies by coughing is lost.

Hæmorrhage. This operation is naturally accompanied by severe hæmorrhage, which in a considerable number of cases ends fatally. This is met and limited by rapid operation, pressure, direct or to the carotids; and some operators recommend the ligation of the common or of the external carotids as a preliminary step. As the ligation of the common carotids has a mortality at least as great as the removal of the bone without it, the procedure is not likely to have many advocates, and probably will be done but seldom in the future. On the other hand, the ligation of both external carotids is comparatively safe and facilitates the ease with which the operation is completed.

Bryant also claims that it decreases the growth of tumors to a great extent, and probably retards the tendency to return after removal. From these considerations I believe it to be commendable, and shall in future employ it in very vascular and rapid-growing tumors.

The first case presented by me is of especial interest because of the occurrence of sarcoma; half of the lower maxillary bone on the same side was removed nine years before. From the fact that the tumor removed by me was closely attached by a dense pedicle near the glenoid cavity, it seems possible that recurrence took place in the periosteum around the end of the removed bone, and the growth afterward extended to the upper maxilla, illustrating the fact that these tumors tend to recur in the periosteum of the bone when they primarily spring from that tissue.

The second case represents the great rapidity of growth of some of the sarcomata. It was first noticed about four months before removal and six months before death from extension to the cranial cavity.

The most disappointing feature about these cases is the great frequency of recurrence. Few cases escape this, but with the better understanding of the dangers of these tumors by the laity, as well as by the profession at large, I believe that in the future earlier operations will be done, and more permanent cures will result.

Before closing I wish to refer to one very remarkable operation reported by

Mr. Earle, who, in 1831, removed the right superior maxilla for fungoid growth. The common carotid was first tied, and the night after the operation the patient was bled a pint. In spite of this, the patient is reported to have recovered. In connection with this I will borrow a quotation from Bryant:

"Man yields to custom as he bows to fate.
In all things ruled, mind, body and estate.
In pain and sickness, we for cure apply
To those we know not, and we know not why."

These lines were written by Crabbe one year afterwards and it is barely possible he had heard of this remarkable case treated by this surgical Sangrado.

Special Abstracts.

THE TREATMENT OF UTERINE FIBROIDS.

Dr. Augustin H. Goelet, in a paper read before the New York County Medical Association (*American Medico Surgical Bulletin*, January 1st, 1894), makes a complete review of the subject. He says the important question which arises in dealing with these growths is, When is interference demanded and what treatment is indicated? A careful review of the literature of the subject and the opinions of those who are entitled to be regarded as speaking authoritativelyleads to the conclusion that the majority do not regard the removal of these tumors indicated unless they give rise to sufficient inconvenience to warrant the risk of the operation and the mutilation which it involves; that the mortality attending their removal is still too great, even in the hands of expert operators, to warrant its being lightly undertaken. If, then, it is possible to relieve the symptoms caused by these growths, the actual necessity for operative interference is narrowed down to a very small field.

The writer does not agree with certain ultra-gynæcologists that these tumors should all be removed when they are small and cause no inconvenience, but he strongly urges that they should be submitted to treatment in this stage, because treatment yields the best results when the tumor is small and of recent growth. The indication for the different methods usually employed are carefully reviewed; electricity, curettement, hysterectomy, and removal of the appendages.

Of electricity he says that frequently a symptomatic cure is all that may be anticipated. The results that may be obtained by this method are classified as follows:

(1) Cure of co-existing endometritis.

(2) Loosening of adhesions between contiguous peritoneal surfaces.

(3) Relief of pain and pressure symptoms.

(4) Control of hæmorrhage.

(5) Arrest and some retrogression of the growth.

The writer takes a bold stand in favor of the vaginal puncture, believing it to be perfectly safe if properly done and strict asepsis is observed; that is, if as much care is taken with this as with other grave surgical procedures. He believes more success would have fol-

lowed the use of this agent if puncture had not been abandoned as a hazardous measure. He believes likewise that it is important to discriminate in the choice of the pole to be employed against growths of different structure; just as important, in fact, as in dealing with such growths as warts, moles and nævi upon the external surface of the body. That is, when the structure is hard and fibrous the negative pole should be selected, and that when it is soft or myomatous, the positive.

The writer lays stress upon the fact that both subperitoneal and submucous fibroids when pedunculated are not amenable to treatment by this agent. He positively declares that though assertions have been made to the contrary in some quarters, the proper use of electricity in these cases does not complicate a subsequent operation for the removal of the tumor; but, on the contrary, its use facilitates the removal of adhesions and produces a marked improvement in the general condition of the patient. In fact, he often employs it for improving the local condition and for building up the health of the patient preparatory to an operation. It has been asserted that the symptoms return after discontinuing treatment, but the writer believes that when this occurs it is either due to a mistaken diagnosis or a faulty technique, which may be unavoidable.

Curettement, he thinks, is useful as a preliminary measure, but it does not yield a permanent result. In support of this opinion attention is directed to the fact that the mucous membrane removed by the curette is rapidly reproduced and the same causes for the hæmorrhage which previously existed still remain. For the control of hæmorrhage when both these measures fail, he advocates ligation of the uterine arteries *per vaginam*, as suggested by Martin, of Chicago. He expresses no confidence in ergot in these cases, but regards it as a useful auxiliary in the treatment of certain submucous and soft interstitial myomata when it is desirable to excite uterine contraction.

Goelet believes that the principal indication for hysterectomy is to be found in large subperitoneal and very large and hard interstitial growths which yield little, if at all, to any form of treatment. In these cases, even if the symptoms are relieved, their size is usually a source of so much inconvenience as to warrant the risk of their removal. This operation would also be indicated where treatment fails to permanently control the symptoms, when the tumor is situated unfavorably for treatment and when complicated by disease of the appendages.

Removal of the appendages for the purpose of inducing an artificial menopause which may exert a favorable influence upon the tumor is not regarded favorably. In his experience, as well as that of others, it is productive of very little good and he strongly urges that when the abdomen has been opened you should not stop short of removal of the whole tumor unless it is impossible to separate it from its attachments.

Fehling, of Basle, has been elected Professor of Gynæcology and Obstetrics at Halle, in succession to Kaltenbach, recently deceased.

SOME SUGGESTIONS AS TO THE TREATMENT OF CEREBRAL HÆMORRHAGE.

Dr. Daniel R. Brower writes that cerebral hæmorrhage is dependent on arterial degeneration. Syphilis, alcoholism, interstitial nephritis, gout, lithæmia, or plumbism cause this degeneration. By examining all the accessible arteries the *tactus eruditus* can detect this degeneration and the malnutrition upon which it is dependent can be corrected so as to lessen the danger of cerebral hæmorrhage.

The arterial degeneration of syphilis is best treated by hypodermatic injections of bichloride of mercury. Chloride of gold and sodium, hypodermatically, is the best way to treat the degeneration caused by alcoholism and interstitial nephritis. The degeneration that belongs to gout and lithæmia needs a careful dietary, attention to elimination, alkalis, salicylates, and colchicum. Iodide of potash gives the best result in the degeneration of plumbism.

In all the varieties an easily digested and nourishing diet is of importance. Careful attention to the functions of the skin, bowels, and kidneys. The heart requires attention that it be neither too strong nor too feeble. In high arterial tension, nitro-glycerine is indicated, and in low tension digitalis and nux vomica. To produce sleep, paraldehyd, chloralamide, somnal, and hyoscine hydrobromate are given. If an artery ruptures, lower the intra-cranial pressure by bleeding the patient into his own vessels with active cathartics, of which croton oil is the best. Another way is to apply ice to the head, heat to extremities, and tincture of aconite and bromide potash internally. An active brain circulation accompanied by fever and delirium is often produced by the encapsulation of the hæmorrhagic focus. This is controlled by blisters, arterial sedatives, and bromides. The use of the iodides with mercury and the constant current will aid in the absorption of the clot. A large positive electrode over the forehead and another, the negative, at the nape of the neck. A current of four to five miliamperes, applied for twenty minutes, is sufficient.—*American Medical and Surgical Bulletin.*

HYSTERICAL LOCKJAW.

Dr. George J. Preston says in the *Journal American Medical Association,* January 27th, 1894:

It is always interesting to observe the manifestations of hysteria in limited and definite areas, because if anything like a distant pathologic lesion is discovered it will be in such cases. Conditions causing widespread hysteria with multiform symptoms are, like widespread lesions in the brain, too complex for purposes of minute investigation or exact localization. It is to the limited lesions that we must look for a starting point, lesions occupying areas sufficiently circumscribed to permit of thorough examination and careful comparison with corresponding normal regions. Such conditions for example as contracture of a single limb, or a single group of muscles, monoplegia, blephorospasm and the like. These minor symptoms of hysteria do not attract the same attention as the more marked and extensive manifestations of the disease, and are perhaps often overlooked by the general practitioner, or at least disregarded. For

the reason given above, however, it is very necessary that these isolated symptoms should receive careful attention, and the clinical picture of the most frequent of them carefully drawn, for at rare intervals opportunites will occur to investigate the region of the brain to which such symptoms can be referred. The following cases illustrate a form of hysterical contracture, which although it was recognized many years ago, is not often described.

CASE 1. Negress, age 19. Convulsions, ovarian tenderness, headache and other classic symptoms. After every convulsive seizure she had rigid contraction of the temporal and masseter muscles, preventing opening of the mouth. The lockjaw continued for some hours or longer after the convulsions, and did not reappear until the next convulsive seizure. There was no record of any rigidity of the muscles of the neck or other parts of the body.

CASE 2. Negress, age 20. Gave a history of having cut her finger three days prevous to the onset of the lockjaw. As long as she was undisturbed and quiet there was no contracture, but upon the least excitement the jaws became so tightly closed that it was impossible to open them without using more force than was considered safe. There was also spasmodic contracture of the muscles of the neck and shoulders. Patient was cured by two or three applications of the faradic current, aided by suggestion. She was kept under observation for some days before any suggestive treatment was instituted and treated with antispasmodics with no benefit.

CASE 3. A young woman of about 20 years was brought to me with the history of having been unable to open her mouth for more than a week. The attack had come on suddenly, and as far as could be learned there was no emotional shock preceding it. She was of a rather hysterical temperament, but there was no permanent stigmata except the contracture of the jaw muscles. There was little or no stiffness of the neck; the teeth were tightly clenched and the greatest force that was considered safe could not overcome the contraction. Her teeth were blackened by the food and medicine that had been poured into her mouth. As the patient was rather apprehensive of hypnotism, the non-hypnotic suggestion was employed. She was carefully placed in front of a large battery, and a mild galvanic current passed through the face, the electrodes being placed one on each side of the jaw. This current was alternated with a faradic current, repeated suggestions being made that in a certain time by the watch she would be cured. In a few minutes the contracture disappeared.

In Case 2 there was the suggestion of lockjaw from the cut finger, but in the other cases there seemed to be nothing to suggest it, nor did the patients allude to their affection as lockjaw.

Incidentally the last two cases illustrate the value of non-hypnotic suggestion. The most important and useful lessons we have learned from the study of hypnotism, which has been carried on with such ardor by the French school during the past half-dozen years, is that non-hypnotic suggestion is far more generally appliable, in many cases is potent as the hypnotic suggestion, and the impression made is more enduring.

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BALTIMORE, FEBRUARY 17, 1894.

Editorial.

THE INCREASE OF SMALL-POX IN DIFFERENT LOCALITIES.

We are constantly reminded through the secular and medical press of the prevalence of small-pox in various localities. This loathsome disease continues to make its appearance, first in one place, then in another, both in this country and in Europe. At this time of writing the disease prevails in mild forms as an epidemic in a number of localities in England and on the Continent, and in New York, Pennsylvania, and in Virginia small epidemics have broken out in several communities. In view of the fact that we have such a sure preventive for this disease in vaccination there seems to be no possible excuse for the prevalence of small-pox. The occurrence of the disease should be regarded as a reflection upon the present system of enforcing vaccination and revaccination, and as an indication of too great indifference to the claims of preventive medicine.

It is quite evident that the health officers of many localities are either careless in enforcing vaccination or incapable of dealing with a prophylactic measure of such wide application.

We are inclined to think that both the public and the medical profession are to some extent responsible for the inefficient methods employed in enforcing, as well as in employing vaccination. Infants, children, and often adults, fail to be vaccinated until small-pox breaks out in a community. In this way the disease gets under headway before vaccination is employed.

It seems unaccountable that it should become necessary at this day to argue in support of a prophylactic measure so efficient as vaccination, yet such is the skepticism of many minds that the value of this measure is not only questioned but actually denied by many intelligent people.

Recent statistics seem so conclusive that we need only read the evidence to be convinced of the real value of vaccination.

During the year ending April, 1893, 513 cases of small-pox were admitted to the small-pox hospital in the borough of Halifax, England (*Lancet*, January 20, 1894), of which number 44 died. The vaccinated cases numbered 425, with 8 deaths, or 1.8 per cent. mortality; the unvaccinated 88, with 38 deaths, or 40.9 per cent. mortality.

There were 2 cases in revaccinated persons, one having been "revaccinated inefficiently five years ago, the other revaccinated thirty-four years ago." As

regards age-incidence, of the vaccinated group no cases occurred under five years of age, 0.9 per cent. from five to ten years, 20.2 per cent. from ten to twenty, 34.3 per cent. from twenty to thirty, 26.8 per cent. from thirty to forty, and 17.6 per cent. from forty and upwards; whilst of the unvaccinated 56.8 per cent. were under five years of age, 17.0 per cent. between five and ten years, 5.6 per cent. between ten and twenty, 5.6 per cent. between twenty and thirty, 6.8 per cent. between thirty and forty, and 5.6 per cent. between forty and upwards. Another table shows that the mortality rates per cent. of attack amongst the vaccinated were *nil* at ages five to ten, 1.1 at ten to twenty, 0.6 at twenty to thirty, 0.8 at thirty to forty, and 0.6 at forty and upwards; whereas amongst the unvaccinated the mortality rate was 40.0 per cent. at age "under five years," 11.7 per cent. at five to ten; 20.0 per cent. at ten to twenty; 60.0 per cent. at twenty to thirty; 100.0 per cent. at thirty to forty; and 80.0 per cent. at forty and upwards.

The severer forms of the disease occurred in but small proportion among vaccinated persons, whilst among the unvaccinated the preponderance of severe cases was marked.

The practical conclusions to be drawn from these statistics are these: In the vaccinated group under five years the method was absolutely preventive. Subsequent to this age, the percentage of cases of small-pox increased from year to year, showing clearly that revaccination is necessary at intervals varying from five to ten years. The mortality and severity of the disease bear the same ratio to the age of vaccination.

The difference in rate of mortality in the vaccinated and unvaccinated classes is the most striking argument in favor of vaccination which could be advanced.

These statistics have been borne out by previous observation, yet it seems necessary to repeat this argument from year to year to induce the profession and public to take a serious view of this question.

PROFESSOR THEODORE BILLROTH.

There are few names in the profession of medicine more familiar to the medical practitioner than that of Billroth. The death of this great surgeon, at the early age of 65, comes to all in the ranks of our profession with sadness and regret. Billroth's distinguished career in surgery began when he was comparatively a young man, and for over thirty years he has filled a conspicuous position as a teacher and operator.

He led the advance in the modern progress of surgical art and science, and occupied the same relation towards surgery which Virchow occupied towards pathology, Claude Bernard in physiology, Marion Sims in gynecology and Sir Andrew Clarke in medicine.

He was a daring, original and successful surgeon, and through his work and teachings led many younger men into lines of work which have resulted in vast good to surgery and to the human family.

His clinics were famous, and students were attracted to Vienna more through the influence of his name than by any other man of the Vienna school. He was indifferent to his pecuniary success

and worked with more regard for science than for honors and pecuniary emoluments.

He was born at Bergen, Rugen Island, on April 26th, 1829, and died at Abbiza, a well-known Austrian winter resort, on February 6th. His health had been poor for some time. The remote cause of his death was heart disease.

He was educated in the Universities of Gottingen, of Berlin and of Vienna. He began his career as a privat-docent in Berlin in 1856. In 1859 he became professor of surgery in Zurich, and in 1867 began his work in Vienna, where he resided until his death.

Thus has passed away a man of brilliancy and power, an ornament to his art and an honor to science. His influence over surgery will long remain as a monument to his energy and dexterity.

A DEPARTMENT OF PUBLIC HEALTH.

At the last meeting of the American Medical Association, a committee was appointed with Dr. C. E. Comegys, of Cincinnati, as chairman, to formulate a bill to establish a Department of Public Health in connection with our National Government.

The committee has recently given out the text of this bill, which will be presented to the present Congress for its action.

The bill provides for a Department of Public Health under the management of a Secretary of Public Health, who shall be a member of the Cabinet; that the Secretary shall be appointed by the President from the medical profession by, and with the advice and consent of the Senate; also for the appointment of an Assistant Secretary by the same authority. The Secretary is to receive an annual salary of $8,000 and the Assistant Secretary an annual salary of $5,000. The sum of $50,000 is asked as an annual appropriation for the support of the Department.

This bill instructs the Secretary to provide for the investigation of all kinds of sanitary questions and to collect statistics and information relating to the public health.

The duties of the Department are broad and comprehensive and cover a multitude of details. In our opinion the bill is more desirable than the one introduced by the committee appointed by the New York Academy of Medicine.

It is questionable, however, whether Congress can be induced to create a Department of Health at this time. That this bill will ultimately become a law in a modified form we do not doubt. We believe that the profession can exercise a very strong influence in securing the enactment of a law which will create a Department of Health.

No one who is conversant with the sanitary condition of this country will deny the fact that such a Department is needed, or that it will fail to exert a most beneficial influence over the public health.

Congress has recognized the interest of the agricultural class by creating a Department of Agriculture. A Department of Public Health will exercise a similar influence over every class of citizens, and seems in this enlightened age as important as the Department of War

or of Navy. The loss to the Nation by sickness and death from preventable disease is tenfold greater than by war, whilst the monetary interests involved exceed those which come within the control of the Department of Agriculture. We, therefore, urge the profession to give consideration to this proposed measure of legislation and to aid in the passage of the bill by Congress.

THE CONGRESS OF AMERICAN PHYSICIANS AND SURGEONS.

The above-named Congress will hold its next session in Washington, D. C., on May 29th, 30th and 31st, and June 1st, under the presidency of Dr. A. L. Loomis, of New York. The preliminary programme just issued presents a list of most instructive subjects to be presented for discussion by a number of the Associations taking part in the Congress.

General sessions of the Congress under the direction of these Associations will be held daily from 2 to 3.30 P. M. and from 3.30 to 5 P. M., at which the subjects will be discussed.

Social and business meetings will be held at intervals during the sessions of the Congress. The Congress has already exercised a most wholesome influence over the work of the various organizations admitted to its membership and there is every reason to anticipate a most interesting and instructive line of work from the forthcoming meeting. Every third year the annual meetings of the different special organizations holding membership in the Congress are held in Washington, and the usual programme of these regular meetings is observed in addition to the work done by the Congress.

Medical Progress.

SUBACUTE MASTITIS AND CANCER OF THE BREAST.

In *L' Union Medicale*, March 21st, Reclus gives a valuable clinical lecture on the differential diagnosis of subacute mastitis and carcinoma. Subacute mastitis has for its causes, usually, traumatism and lactation. The tumefaction of the breast, the indolence of its course, the thickening and induration of the skin, the retraction of the nipple, the absence of fluctuation—these signs all belong particularly to cancer, but they may likewise accompany a subacute mastitis. While lactation predisposes to mastitis it does not preclude cancer. While pain is in favor of mastitis, still it is far from being decisive. The same is the case with glandular involvement; in mastitis it is apt to be more violent and rapid. The various symptoms taken individually are not at all reliable, and it is only by considering all the symptoms of the case that its nature can be correctly diagnosed. Oftentimes a few days or at most a few weeks will resolve all doubts. Care should be taken not to amputate a breast affected only with mastitis, nor, as occurred in one of our cases, open a fluctuating cancerous nodule for a simple abscess. One should, above all, not forget that true pathognomonic signs do not exist, but that it is necessary to examine all the symptoms and especially the mode of onset and development, and whether or not it is connected with lactation.—*Ex.*

MARRIAGE, DYSMENORRHŒA AND HYSTERIA.

Dr. Wythe Cook, Washington, D. C., in the *Amer. Journal of Obstetrics*, Dec., 1893, writes that from experience in most cases of dysmenorrhœa and hysteria amongst single women marriage aggravates the disease. Hysteria is by no means cured by marriage, dysmenorrhœa often returns after pregnancy. One patient suffered from very severe dysmenorrhœa. She married, on advice, but the disease was aggravated by coitus. Conception occurred, and she fully believed that pregnancy would cure her, but the menstrual pain returned immediately after weaning. Another patient, subject to dysmenorrhœa, married when 20, and became pregnant when over 23. She bore a healthy child, and then took to the morphine habit. Her husband died a few months after her confinement. The period was suppressed for five years. After she ceased to take morphine it reappeared, at first irregularly, and at length in due season, but in both cases there was severe pain. She married again, and has remained eighteen months sterile; the dysmenorrhœa continues. A young woman subject to headaches and hysterical manifestations attended with hallucinations and depression got married. The neuroses were not improved by marriage. A robust young lady free from hysteria married and bore two children within twenty-one months after marriage. Hysterical swoonings occurred during the pregnancies. A patient subject to dysmenorrhœa and hysterical fits married and bore five children. The menstrual pain never reappeared after the first pregnancy, but the fits still occur.

A NOTE ON TUBERCLE BACILLI IN HOUSE DUST.

R. Shalders Miller, M. B., B. S. Lond., F. R. C. S., writes to the *British Med. Jour.*:

In April, 1892, it occurred to me to examine dry dust from a house in which there had been a series of cases of phthisis. I will briefly relate these in chronological order.

About fourteen years before the above date a gentleman affected with phthisis lived in the house, and left it only a short time before his death. An old lady then lived in the house for about six years, and died there, but not from the same disease. Then a lady, a family connection of my own, with her five daughters, took up her residence there, four of the girls being most of the time at school. In a year this lady became the subject of phthisis. She lived for three years, and then died of that disease. During her illness the eldest daughter showed symptoms and slight physical signs of the same complaint, and came to stay at my house for about six weeks. She returned home apparently well, and has remained in good health ever since. A few months after the mother's death the second daughter, who had not long left school, displayed similar symptoms, and also came to stay at my residence, and fortunately recovered her health. She is still alive, and perfectly well and strong.

Early in January, 1892, the third daughter, who had left school only the previous Christmas, and had been suffering from a severe cold, exhibited consolidation of the left apex. She was a plump, but delicate girl, who had experienced a good deal of illness in child-

hood from bronchitis and a severe attack of pneumonia. This poor girl, who was about 18 years of age, also came to stay at my house for about seven weeks, but she became rapidly worse, general infection taking place quite suddenly from the bursting of a tuberculous nucleus into one of the bronchial tubes, and she died exactly a month after returning home.

Several times during her visit I made stained specimens of sputum, and found an ever increasing prevalence of tubercle germs. I also obtained samples of dry dust, six in all, from various parts of her home. Unfortunately five of the six were ruined in the course of preparation, but the remaining one, scraped off the top of the dining room door, showed no fewer than eight groups of tubercle bacilli on a single microscopic slide; one of the groups numbering several hundred germs.

After this I had their house fumigated with sulphur, and advised vacating it, which has since been done. The house was an old one, largely constructed of wood, and I much doubt if anything short of burning it down would be adequate to destroy its infective qualities. It would be hardly fair to ask workmen to pull it down. I communicated the above facts to Dr. Douglas Powell, who had very kindly seen this last patient.

Since then I have learned from one of the medical journals that very similar observations have been made, in almost parallel circumstances, by a Paris physician whose name I do not now recall.

VEGÆTARIANISM AND CRUEL TEMPERAMENTS.

There has been much written on the mildness of temper possessed by vegetarians. The Hindoo professional assassin or murderer is probably as cold-blooded and as ferocious a being as one may imagine. The Chinese are great vegetarians—rice, beans in the green state, cabbage and large spinach, water-cresses and fruits enter largely into their diet—they are, besides, very fond of fish, and yet there is nothing more bloodthirsty and bellicose, more wild or more unmanageable, than the Chinaman when aroused. On the other hand, the native Californians, like to the native or dweller of the wild Pampas of South America, who lived on an exclusive beef diet, were generous, self-composed and not in the least given to either strife or bloodshed. —*The National Popular Review.*

CAUTION TO ANÆSTHETIZERS.

During a recent clinic by Prof. Hunter McGuire in the new amphitheatre of the College of Physicians and Surgeons, Richmond, Va., while chloroform was being administered to a patient on whom excision of portions of the bones of the leg was about to perform, the patient suddenly stopped breathing, the face became purple, etc., while the heart continued to beat. In a moment, Dr. McGuire recognized that the condition was due to the dropping back of the tongue, obstructing breathing. With thumbs behind the rami of the inferior maxilla, he pushed that bone forward, thus lifting up the tongue, and the patient at once began breathing easily, and was kept thoroughly under the anæsthetic for the time necessary for the operation. While this procedure is not, by any means, a new one, it is worth while to record such incidents so as to keep the surgeon or physician well on his guard so

as to act at the moment when by-standers are dazed by the shock of an impending accidental death. In short, in using an anæsthetic, keep your wits about you, and look out for the sudden emergencies. —*Virginia Med. Monthly.*

ABORTIVE TREATMENT OF GONORRHŒA WITH OIL OF CINNAMON.

Dr. J. C. DaCosta advocates the thorough flushing of the urethra followed by the application of an antiseptic. He says:

For many months past Dr. D. Braden Kyle has been engaged in our private laboratory in a series of experiments in regard to the properties of the oil of cinnamon. He found this substance to possess the most remarkable antiseptic powers (the report will soon be published), and used it in the treatment of infective and non-infective inflammatory conditions of the nasal and aural passages, with most gratifying results. His success induced me to employ the agent in the treatment of gonorrhœa. The oil can be applied once daily by means of the atomizer (and this plan is most efficient, if the physician applies it himself, or the patient is sufficiently intelligent to do so). The oil is mixed with benzoinol in three degrees of strength, 1 drop, 2 drops and 3 drops of the oil respectively to the ounce of benzoinol. On the first day solution No. 1 is used (one drop to the ounce); on the second day solution No. 2, and after this solution No. 3. The benzoinol serves the useful purpose of causing the thorough diffusion of the oil, and also causes it to adhere with considerable tenacity to the mucous membrane. Dr. Horwitz prefers to use the oil by injection, employing a solution of the same strength in albolene or benzoinol. This plan I have tried, and believe it to be the best when the patient lacks intellegence, and is obliged to largely carry out his own treatmeut.

It is in beginning gonorrhœa that oil of cinnamon finds its most useful field. In acute, thoroughly developed cases, its employment induces considerable pain; but, though it does not check the disease, it causes abatement of the *ardor urinæ*. In chronic cases it also seems of considerable use. I am far from claiming to have found a specific, but I am quite sure that cinnamon is a valuable remedy in certain cases of gonorrhœa. In forty cases of beginning acute urethritis, clinically recognized as gonorrhœa, of from three to five days' duration, the following results were obtained;

In six cases the discharge ceased in two days and did not return; in 12 cases the discharge ceased in five days; in 6 cases the discharge ceased in from eight to ten days; in ten cases the discharge ceased in from ten to fifteen days; in 2 cases the treatment failed entirely, and was abandoned after two weeks; 4 cases did not return after the first visit.

No other treatment was used, although ordinary hygienic and dietetic precautions were taken. Dr. Horwitz informs me that 15 beginning acute cases under his observation were cured within ten days. In 10 cases of chronic gonorrhœa, without apparent stricture or granular patches, the treatment proved successful: 4 cases were cured in two weeks; 3 cases in three weeks; while 3 cases were benefited but not cured. In no case was a complication observed.

These observations, chiefly made in the Jefferson College Hospital, would seem to justify the conclusion that oil of cinnamon is of value in the treatment of beginning gonorrhœa and of chronic gonorrhœa. Whether or not the drug will prove of benefit when given internally, future experiments will show.

The injections should be made three or four times a day, immediately preceded by micturition and cleansing of the urethra with hydrogen dioxid. In cases in which considerable pain is caused by the injection, the weaker solutions should be used, and retained for but a short time.

The irritant injections, if strong solutions are used, seem to favor the development of stricture, an objection from which oil of cinnamon appears to be free.—*Phil. Med. News.*

FREAKS OF HEREDITY.

At a recent meeting of the Paris Hospital Medical Society, M. Marie showed the photograph of a woman with supplementary mammæ, and stated that nearly all the members of her family, for four generations back, had presented the same anomaly. Moreover, among her father's fifteen brothers and sisters there had been six twins, and among her own brothers and sisters, twelve in number, eight twins. All these fourteen twins were of the male sex, showing that the tendency to beget twins could be transmitted through the male line. Another example of this possibility was cited by M. Le Gendre—that of the Scotch poet, Burns, who was alleged to have become the father of twins four times—twice by his wife and twice by his mistress.—*Western Med. Reporter.*

Medical Items.

Dr. George H. Fox, of New York, has been elected President of the Medical Society of the State of New York, for the ensuing year.

The Methodist Episcopal Hospital, of Boooklyn, has received a donation of $5,000 under the will of the late Mrs. Lucy Williams, of Pittsfield, Illinois. The gift is designed to endow a bed.

The German Hospital, of Brooklyn, has funds amounting to $120,000. It is expected soon to lay the corner-stone, and when that has been done an increase of the endowment fund will be easier to accomplish.

The Chattanooga Medical Society has expelled a member, Dr. Edward F. Kerr, for publicly endorsing the "Keeley cure." Dr. Kerr was a graduate of Chicago Medical College, and, aside from his drinking habits, was a physician in good standing, It seems that he had taken the "cure" himself.

A board of medical officers will meet Monday, April 16, 1894, in Washington, D. C., for the purpose of examining candidates for appointment to the grade of Assistant Surgeon, in the Marine Hospital Service. For further information address The Supervising Surgeon-General, U. S. Marine Hospital Service, Washington, D. C.

Christopher Heath, in reporting an operation for stone by the high method, in which chronic cystitis existed, says that he applied to the lining membrane

of the bladder a solution of silver nitrate, 20 grains to ℥j water through a vulcanite speculum. This treatment almost immediately changed the alkaline and offensive urine to an acid and comparatively healthy secretion.—Dr. B.W. Taylor, in *Med. News.*

The Gynæcological and Obstetrical Society of Baltimore has appointed five of its members, Drs. J. E. Michael, Wilmer Brinton, B. B. Browne, G. L. Taneyhill and T. A. Ashby a committee to draw up a bill, and to present the same to the Legislature, to provide for the registration and licensing of midwives.

An appeal to the people, through the advertising columns of daily (lay) newspapers, is being made to further the sale of the "Animal Extracts, prepared according to the process and under the supervision of Dr. Wm. A. Hammond." An extensive advertisement appeared in the advertising columns of the Chattanooga *Daily Times*, of January 19, 1894. Comment is unnecessary !—*Med. News.*

Dr. J. B. Hinkle, of Americus, Ga., who for many years was Speaker Crisp's family physician, was recently found guilty of murder. A year ago the doctor and his son, who is also a physician, shot and killed a professional rival, Dr. Worsham. Between the men there had been a feud of years. The trial has been regarded as one of the most noted in Georgia. Dr. Hinkle's son will be placed on trial for the same offense.

At the regular meeting of the Shreveport, La., Medical Society, the following officers were elected for the ensuing year: President, Dr. J. C. Eagan; Vice-President, Dr. T. E. Schumpert; Recording Secretary, M. K. Vance, M. D.; Corresponding Secretary, Dr. Randall Hunt; Treasurer, Dr. J. J. Scott. Dr. M. K. Vance read a very elaborate paper on tubercular meningitis, which was highly complimented by the fraternity present. Dr. S. H. Hicks was appointed essayist for next meeting.

The Cincinnati Obstetrical Society, at its regular annual meeting, held at the residence of Dr. R. B. Hall, elected the following officers for the ensuing year: President, Dr. T. P. White; Vice-President, Dr. R. B. Hall; Secretary, Dr. E. S. McKee; Corresponding Secretary, Dr. W. D. Porter; Treasurer, Dr. G. E. Jones. The Society resolved to meet the first and fourth Thursdays in each month instead of monthly as formerly.

Unfortunately for Georgia, the bill to regulate medical practice in that State has failed to become a law. Its defeat is placed at the door of the eclectics. This means that Georgia is likely to continue a particularly fertile field for cheap medical schools and cheap doctors. The regular profession in that State may take heart, though, and profit by the advancement Kentucky has made in this line. The quacks here, like the Arab, are folding their tents and quietly stealing away. Patience, perseverance and diligence.—*Med. Progress.*

The French Minister of Public Instruction has issued certain regulations regarding the management of children sick with diphtheria, where those children are attending school. The period

of exclusion of the sick child is placed at thirty days; successsve disinfection must be practised; no fruit may be consumed by the children during play hours. In respect to scarlet fever, the period of exclusion must be forty days and the school must be closed if several cases spring up within the first five days after the disease has been verified.

The South Georgia Medical Association has been permanently organized at Helena, Ga., and will meet quarterly on the first Tuesdays in March, June, September and December. It has a membership of about forty regular physicians, with Dr. G. W. Blanton, of Chancey. President, and Dr. H. J. Smith, of McRae, and J. D. Herman, of Eastman, Vice-Presidents, and Joseph A. Estes of Eastman, Secretary and Treasurer. This Association is intended as an ally to the Georgia Medical Association. All the physicians in the State who are graduates of a regular school of medicine in good standing are invited to membership.—*Atlanta Med. and Surg. Jour.*

The *New Orleans Medical and Surgical Journal* was established in 1844. With the end of the current volume, June, 1894, the Journal will have completed fifty years of useful life. On the threshold of its half-century the Journal finds itself with a larger circle of subscribers than it has ever had before—at least since the close of our great civil conflict. It is the intention of the present management to follow the example of another southern publication, the MARYLAND MEDICAL JOURNAL, upon attaining its fiftieth year—namely, to make the Journal a semi-monthly instead of a monthly. Details of the changes to be introduced will be given later.—*N. O. Med. and Surg. Jour.*

Our State and city charities cost $7,468,819, annually, other benevolent institutions cost $14,939,163, making a total of over twenty millions for charitable, correctional, and reformatory purposes. The total number of the submerged class was 80,543. During the ten years between 1883 and 1893 the expenditures have doubled, showing a ratio of increase nearly four times greater than that of the State's population. The Board thinks that much of this increase in the insane, as well the increase in pauperism, in the State, comes from the greatly increased immigration from central and southern European countries, many of them weak and defective, with tendencies to insanity. The Board urges the establishment of a colony for epileptics, and repeats its recommendation of last year that a new reformatory for men be established near New York and Brooklyn.—*Med. Rec.*

The Illinois State Board of Health amended the schedule of requirements for admission to medical colleges by taking out of the hands of the college the examination in the elementary branches of education, and requiring either a certificate or diploma from a literary and scientific college or high school or, at least, a second grade teacher's certificate. A curriculum of studies for schools of midwifery was also adopted. A committee was appointed to draft an outline of sanitary work throughout the State, and the Secretary was ordered to issue a "preventive disease" circular on tuberculosis.

The officers were re-elected as follows: Dr. William E. Quine, Chicago, President; Dr. J. W. Scott, Springfield, Secretary; and Dr. B. M. Griffith, Springfield, Treasurer. The Governor has reappointed Dr. Julius Kohl, of Belleville, a member of the Board.

The next meeting of the American Gynecological Society will be held in Washington, on Tuesday, May 29th. According to the resolution adopted at the last meeting, the morning sessions of the first two days will be devoted to the discussion of the following subjects: 1, Extirpation of the uterus in disease of the adnexia; 2, the management of face presentations; 3, rupture of the uterus: surgical *vs.* expectant treatment.

The afternoon of the third day will be devoted to a special discussion before the Congress, under the direction of the American Gynecological Society. The following topic has been assigned: "The Conservative Surgery of the Female Pelvic Organs." Referee, Dr. William M. Polk; co referee, Dr. William Goodell. Since there will be time for only twelve or fifteen papers in addition to the above discussions, those gentlemen who desire to contribute are requested to send the titles of their papers to the Secretary on or before April 1st, as he will be compelled to limit the number to the first fifteen which he receives. The Fellows are reminded of the By-law: "All papers that may be read before the Society, and accepted for publication, shall become the property of the Society, and their publication shall be under the control of the Council. Such papers may be published in full in medical journals provided that they are also printed in the 'Transactions.'" There are eleven vacancies in the list of Fellows.

Mrs. Ernest Hart, the wife of the editor of the *British Medical Journal*, has during the past year become personally known to thousands of Americans, and the knowledge of her work to millions. In carrying to the Irish poor the means and methods of self-help this most remarkable woman has done a work that is good beyond estimation and compare, and has done it with a self-sacrifice that even those who know her most intimately can but barely guess. What the history of her life would be was well suggested by her refusal, as a girl, to wear fine or expensive dresses to church, and as a young lady, by her return of a gift of diamonds with the request for Ruskin's works instead. Such girls as that and such women as she, are indeed sadly rare. While teaching the starving Irish to dye and weave, and at the same time carrying on any amount of other work among the poor of London, this many-minded woman has also kept her place in the best society of London, has been an art-lover and worker and a student of the social life and handicrafts of nearly every country of the world. But our explanation of this allusion in a medical journal consists in the fact, known to but few, that Mrs. Hart before doing these things had passed with the hightest honors the most rigorous examinations of the medical faculties of Paris, and by thorough hospital service had completed a perfect knowledge of medicine both theoretic and practical. Wherever she goes physicians should vie with others in hastening to do her will, and to do her honor!—*Med. News.*

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THE LIMITATIONS OF THE USE OF THE PESSARY.*

BY HUNTER ROBB, M. D.,

Associate in Gynæcology, Johns Hopkins University, Baltimore.

Mr. President and Gentlemen:—In the paper which I wish to present to you to-night I shall bring forward some of the principal reasons which tend to show that the use of the pessary in the treatment of displacements of the uterus, far from being always necessary, is, in the great majority of such conditions, contra-indicated. I do not pretend to believe that my arguments will prove convincing to all and I am not altogether sorry for this, as I think the subject is a very interesting one for general discussion, and I hope that when I have finished many of our members will give us the benefit of their experience as far as it bears upon this subject.

For the earlier gynæcologists the pessary was almost a panacea in the treatment of real or supposed displacements of the uterus, and even to-day it still holds a somewhat prominent position in the armamentarium of many specialists. A few years ago it was (and is still) in many of our dispensary services the routine method in the treatment of patients who came suffering with symptoms of pelvic disorders, whenever an examination of the pelvic contents had satisfied the examiner's mind that the uterus was either too far forward, or displaced slightly backwards, to fit a pessary and advise that it should be worn for a shorter or longer period until the displacement should have disappeared,

*Read before the Gynæcological and Obstetrical Society of Baltimore, Feb. 13, 1894.

Not only in the catalogues of the instrument maker do we find a great variety of pessaries pictured, but also in well-known text-books on Gynæcology it is interesting to observe the vast amount of ingenuity which has been expended upon the many different forms of pessaries which have been devised for the treatment of any one kind of displacement of the uterus. Neither can we be surprised if the average practitioner is often at a loss which to chose even after he is convinced in his own mind that the diagnosis is clear. Fortunately we believe that nowadays there are very few cases in which we cannot accomplish much more beneficial results by more rational treatment. It is to be feared that in many instances in which the patient comes to the physician complaining of some pelvic distress, a pessary is employed almost by way of a placebo, even when no uterine displacement has been definitely made out. Such a practice is thoroughly reprehensible, since it might be productive, as we shall show, of very serious consequences, and the chances that it may do good are too slight to warrant the incurrence of so great a risk.

Granted, then, that a pessary may sometimes be useful where a displacement exists, the condition by itself does not necessarily warrant its employment. It takes a great deal of practice and experience before a physician becomes able to decide intelligently as to the position of the uterus; and to make a correct diagnosis as to the condition of the lateral structures is a much harder task. Supposing a displacement of the uterus to exist, if at the same time there is present an inflammatory condition of the adnexa, the employment of the pessary may be productive of considerable harm.

As an example of how rashly and unscrupously some women are subjected to the use of the pessary I would cite the following instance. While in an instrument shop in one of our large Northern cities, the proprietor showed me a letter from a physician in the country, and asked me to kindly advise him what sort of a pessary he should send. The writer of the letter simply stated that he had a patient who was suffering with a displacement of the uterus and asked the instrument maker to send him a pessary. The letter contained no further details. One can readily see how much injury might be produced by such an indiscriminate use of the pessary.

I do not think that these criticisms can be confined to the general practitioner, for there are not a few gynæcologists who fall into error from too great a readiness to attribute a patient's symptoms to slight displacements of the uterus. Before being able to feel positive that such is the case, we should be obliged in the great majority of instances to make the patient submit to a careful examination under an anæsthetic in order to exclude a pathological condition of the adnexa. Even supposing that the latter are not affected, we have come to the conclusion after observations extending over 8 years on a large number of cases that there exist but few cases of anteflexion or anteversion of the uterus which require the use of the pessary. As a matter of fact, it is a difficult question to decide what is the normal position of the uterus for any given individual, and while one man after a

vaginal examination might think that an anteflexion or anteversion of the uterus existed which was sufficient to account for all the symptoms complained of by the patient, another would be of an entirely different opinion. To attribute the patient's sufferings to a slight, or even a well-marked forward displacement of the uterus is, to say the least, taking a great deal for granted, and as I have said before, we cannot feel even reasonably certain that such is the case until we have excluded the possibility of the existence of an inflammatory condition of the adnexa.

After careful examination we have found a great many instances both in women who have borne children and also in nulliparæ in which the fundus of the uterus was inclined forwards while the whole uterus was sagging in the pelvic cavity. One could scarcely call this a mere forward displacement of the uterus.

But there is still another point which must always be taken into consideration. Even where a displacement of the uterus has been definitely made out and we have excluded beyond doubt the existence of pelvic inflammatory disease, we have yet to ask ourselves whether after all the symptoms complained of are primarily due to uterine disorder and do not result from a nervous condition of the patient.

I believe that many displacements of the uterus can and do exist without causing any unpleasant symptoms and I certainly have seen many cases, in which the pessary had been employed for a displacement, do perfectly well without it under much simpler methods of treatment. Sometimes even when the condition has not been apparently rectified under these measures, the patient has become so well and at the same time so accustomed to the displacement that the symptoms have either entirely disappeared or have been very much diminished.

In many instances in which the uterus was strongly retroflexed I have seen the pessary intelligently employed for some time in order to correct the displacement, without any material benefit resulting therefrom.

The wearing of the pessary when properly applied soon accustoms the patient both from a mental and a physical standpoint so thoroughly to its use and makes her so dependent upon it that she feels as a rule uncomfortable unless it is in the vagina. But, as I said before, this is not all, for in addition there is the great danger of inflammatory changes taking place as a result of its use.

I would therefore respectfully submit the two following propositions: (1) If the displacement is due to inflammatory adherent adnexa, in the majority of instances the pessary would be of no use and the removal of the diseased structures will be indicated. (2) If the symptoms can be demonstrated to be a result of the position of the uterus *per se*, then we can resort to other measures which generally will prove in the long run more satisfactory and which at the same time are free from the dangers which a pessary might produce.

In cases, then, in which the pessary was formerly almost universally used for the correction of a displacement of the uterus, we begin by almost entirely limiting ourselves to hygienic measures for from 6 weeks to 6 months. If these

after a fair trial are unsuccessful we resort to dilating the cervix under anæsthesia and curetting the uterus. In some cases where there is a flexion of the body of the uterus on the cervix we may have an endometritis. The curettement will often relieve the congestion which is not infrequently the result of the displacement and at the same time the dilatation of the cervix will tend to straighten out the uterus and thus prevent the recurrence of such a condition.

When dilatation and curetting have been performed we have after a week's time in some instances made applications to the vault of the vagina with tincture of iodine, the patient being in the knee-breast position, and then have applied tampons of cotton impregnated with 50 per cent. boro-glycerine well around the cervix, and tampons of lamb's wool in front of it. Where these applications have been carried out once or twice a week for two or three months, with the addition of strict hygienic measures, especial attention having been paid to the regulation of the bowels, we have often been able to see very satisfactory results.

It is true that where the patient had been wearing a pessary for some time she would after its removal often complain of a feeling of general discomfort, but after she had submitted conscientiously to the treatment for some time, we have seldom, if ever, found it necessary to reapply the pessary and the patient has become so well that she has experienced no further need or desire for an artificial support.

I have spoken of the limitations of the use of the pessary, but I do not mean to state that there are no cases in which it is advisable to employ it, but I do believe that in the great majority of cases and in the manner in which they are sometimes employed, pessaries are worse than useless. In the Gynæcological Dispensary service of the Johns Hopkins Hospital we have not to my knowledge had recourse to their use more than two or three times within the past year and they have been superseded by other and in our opinion more satisfactory measures.

Among the instances in which the pessary may be used to advantage may be included those cases of prolapsus where for some good reason operative measures are contra-indicated, and also in cases of retroflexion of the uterus occurring during pregnancy where we wish to avoid the dangers of miscarriage and are afraid of adopting any other measures. I need not say that in both these cases the proper application of a pessary will often give very satisfactory results.

When the pessary is employed it will be found advisable to carry out certain rules in order to prevent it from causing any irritation of the parts and at the same time keep the vaginal tissues healthy.

Either the hard rubber Smith-Hodge or the Peaslee soft rubber pessary are to be preferred. One should be sure that the pessary fits well and also that it does not produce any discomfort. It should be removed every two or four weeks so that we may be able to satisfy ourselves that the tissues are not becoming ulcerated or otherwise injured. If it is to be worn for a longer time it would be well for a douche to be taken once weekly, consisting of a pint of a ½ per cent,

aqueous solution of carbolic acid, or the following:

℞.—Pulv. Ac. Boric. 120, (℥iv)
Pulv. Aluminus. 30, (℥i)
Acid. Carbol. 12, (℥iii)
Ol. Menth. pip. 6, (℥iss)

M. Sig.—5 grm (℥i) in 500 c.c. (one pint) of hot water as a douche.

As a rule, when the pessary is removed it will be well if a vaginal douche is given at once. The patient, having been cautioned against any over-exertion, is ordered to go without the pessary for a day or so, and in the meantime it can be thoroughly cleansed and disinfected. It may then be again introduced, the same treatment being carried out every time it is removed.

SYMPHYSIOTOMY.*

BY KARL SANDBERG, A. M., M. D.,
CHICAGO, ILL.

SYMPHYSIOTOMY—division of the symphysis pubis—was first practised on a woman in labor by Dr. J. R. Sigault in Paris in 1777, to allow sufficient separation of the pubic bones to admit of the passage of the living child through a contracted pelvis. The fact, already recognized by the ancient authors, of the relaxation of the pelvic joints during gestation, allowing some enlargement of the superior strait during labor, sometimes even to the extent of a rupture of the ligament and division of the joint, led Pineau to hint at, and later Sigault, at that time a medical student, to propose, a division of the symphysis pubis as a substitute for Cæsarean section. His first patient and the child survived the operation. From 1777 to 1858 there are 86 cases on record. The operation was then practically condemned and given up by the profession, but was revived in 1866 by Morisani and Novi, of Naples. The only modifications they made in the method were to allow the child to be expelled by the uterine contractions, instead of the rapid delivery by forceps or turning as practised before, and probably to substitute the subcutaneous for the open method as practised by Sigault. During the next twenty years the operation was performed in Naples seventy-six times, but it is only within the last two years that the good results published from Italy have induced France (Pinard, in Paris) and later Germany (Freund, Zweifel, and others) to adopt the operation. The operation was performed for the first time in the United States in Brooklyn in September, 1892, by Jewett.

Method of Operation.—There are two methods—the open method, as employed by Sigault and later by most French and German operators, and the subcutaneous or Italian method. Both operations are of course now performed aseptically.

The Open Method.—Incision in front of symphysis pubis, of varying length according to the amount of adipose tissue. The urethra is kept out of the way by a stiff catheter. The incision should extend upward far enough to allow easy access back of the symphysis, and downward in the median line to the root of the clitoris. Some operators make a deviation to one side. The left index finger is then introduced behind the symphysis from above and a probe-pointed bistoury is inserted on this as a

*Read before the Chicago Gynecological Society, December 22d, 1893.

guide; the division of the cartilage is then made from above and behind downward and forward. Only when the last fibres of the ligamentum arcuatum are divided is the full extent of separation obtained. There is considerable hæmorrhage, which some operators think can be controlled only by a tampon.

The Subcutaneous or Italian Method.—Incision in the median line 3 centimetres long, ending 1 to 2 centimetres above the symphysis. Small transverse incisions are made to detach the musculi pyramidales. The left index finger is then introduced behind the symphysis pubis and down to its lower end, and Galbiati's falcetta is slid down on this until its probe-pointed end can be felt under the pubic arch; the symphysis is next divided from below upward and from within outward.

The centre of the symphysis can be ascertained by finding the spines of the pubic bones. The cartilage is generally prominent. If this is not the case it can be found by raising or lowering the legs, whereby a slight motion of the joint is produced. The joint is not always in the median line, but frequently to one side, generally the left, and is often oblique, most commonly from the right side to the left. This probably explains why some operators have found it necessary to complete the division with a saw. That bony union is rare is proved by Dr. Wehle's examination of 25 female cadavers of different ages up to 70 years without discovering bony union.*

The subcutaneous method is simple, gives rise to less hæmorrhage than the open method, and the wound can be kept perfectly aseptic. Hæmorrhage can be treated by tamponing of the wound and by counter-pressure(tampons) from the vagina.

The open method allows full view of the field of operation and enables the operator to find the best place for dividing the symphysis; it also enables him to see the bleeding points and to ligature, suture, or clamp them. But the wound extending down to the vulvar orifice is exposed to the lochial discharge and is very difficult to keep aseptic. It is claimed by some that packing is the only reliable hemostatic.

After symphysiotomy Morisani and Zweifel† recommend non-interference for twelve to twenty-four hours; they consider changes in the fetal heart sounds the only indications for interference. According to Morisani the forceps will be required in only about one-fourth of the vertex cases; spontaneous delivery should be permitted in other cases. He thinks turning ought to be avoided where the head can be made to engage in the superior strait. Garrigues‡ thinks that in most cases the women should be delivered at once, and in the choice of methods he makes it a rule to use version and extraction if the head is movable, and forceps if it is engaged in the pelvis; he also recommends incision of the cervix, if it is not sufficiently dilated. It is considered cruel by some operators to await spontaneous delivery after the operation, on account of the resulting pain and soreness. On the other hand, the advocates of delay claim that there is no noticeable increase in suffering.

*Archives fur Gynakologie, Band xliv., Heft 3, p. 536.

†Archives fur Gynakologie, Band xliv, Heft 3, p. 527.

‡American Journal of Obstetrics, vol. xxviii., No. 5, p. 626.

Out of 44 modern cases,§ the mode of delivery was as follows:

	No. of Cases.	Per cent.
Spontaneous delivery,	8	18.2
Manual aid,	1	2.3
Extraction by feet,	1	2.3
Forceps,	27	61.4
Version,	5	11.4
Unknown,	2	4.4
	44	100.0

After delivery the early operators applied a napkin around the pelvis. The Italians sew up the suprapubic wound and bring the separated pubic bones together by long strips of adhesive plaster. Zweifel‖ drills holes and sutures the bones together; he formerly used silver wire, but now employs catgut. Most operators drain the wound, after the open method of operating, by strips of iodoform gauze brought out at the lower angle of the wound. Garrigues¶ considers nothing better than strips of rubber adhesive plaster applied around the trochanters to keep the two halves of the pelvis together; he uses three strips 5 centimetres wide, crossing them on the abdomen above the wound. While they are being applied, and during after-treatment, the patient should lie with outstretched legs, the knees together and the feet turned inward, as in this position the bones are approximated. According to Zweifel this position also corrects an inclination on the part of the pubic bones to imperfect approximation. Garrigues recommends suture of the soft parts and unites the tendinous tissue in front of the pubic bones with buried sutures, but doubts if this last procedure is necessary. Drainage he considers superfluous. Gueniot has invented a special apparatus to press the pelvic bones together, and Pinard has had a special bed constructed for this purpose.

In regard to the effect of the operation, I shall simply state the most noteworthy observations made upon the living subject or by experiments on the cadaver.

Effect of operation.—Zweifel*: When the head passes through the narrow point of the pelvis the pubic bones separate generally from 6.5 to 7 centimetres. Doderlein†: The right pelvic bones yield more easily than the left, and generally the right sacro-iliac joint, if any, is injured. Garrigues‡: The distance between the middle of the promontory and the end of the pubic bone increases fourteen millimetres, and by the presenting part entering into the gap between the divided bones a further 6 to 8 millimetres is gained, making in all 20 to 22 millimetres. The increase of the other pelvic diameters amount in some cases to as much as 35 millimetres. There is also an increased vertical mobility. Fehling declares an increase of 15 to 18 millimetres in the conjugata vera may be expected from the operation, and that, as a rule, one may expect to obtain a conjugata vera of the same length as the diagonal measured before the operation. Ahlfeld has observed that after division of the symphysis the anterior pelvic ring sinks down. To understand that this also will help to make the conjugata longer, it is only necessary to remind

§Robert P. Harris: American Journal of Obstetrics, vol. xxvi, No. 4.

‖Archives fur Gynakologie, l. c.

¶American Journal of Obstetrics; vol. xxviii, No. 5 p. 633.

*Arch. f. Gynak., l. c.

†Archiv. fur Gynakologie, Band xliv, Heft. 3, p. 532.

‡L. c.

you of Waldier's experiments, corroborated by Dührssen, which showed that in a lying position with the legs hanging down (*Hängelage*) the conjugata vera is about 1 centimetre longer than in the dorso-sacral position. Döderlein (Leipzig), after experiments on the pelvis of women who died shortly after labor, came to the conclusion that by each increase of one centimetre in the distance between the ossa pubis an increase of about 8 square centimetres is obtained in each pelvic plane. A superior strait of 105 square centimetres would, by a separation of the pubic bones to the extent of 6 centimetres, be increased to 155 square centimetres.

Bad effects on the joints.—Baudelocque considered the injury to the sacro-iliac joint fatal when the division of the symphysis reached 6 centimetres, as he shared the erroneous idea of his time that there was a bony union between the two bones which had to be ruptured. We know now that they are connected by a true joint, and that it is only the capsule of this joint and the strengthening ligaments that are torn, and that this in most cases does not take place until the extent of the division reaches or exceeds 7 centimetres. When it occurs a firm fixation and avoidance of sepsis will generally secure a good union without any trouble. In his experiments on cadavers Dr. Wehle§ found great difference according to the patient's age and whether or not she was in the puerperal stage. In advanced age the joints separated upon a division of 4 centimetres between the pubic bones, while in young women shortly after childbirth this took place upon a divison of 8 or 9 centimetres. Faulty union of the pubic bones, resulting in impaired locomotion, was one of the great objections to the operation in its early period. Since its revival, and especially during the last six or seven years, failures in this respect are almost unheard of, whether the operator applies bone sutures or only keeps the divided bones in position by a firm bandage.

Effects on the soft parts.—Injuries to the soft parts—urethra, vagina, bladder, etc.—have occurred and still occur in a number of cases and prove a serious complication. It is probably more reasonable to attribute these injuries to the stretching of the parts between the separated bones than to any direct injury from the forceps or the fetus. To avoid these injuries Zweifel‖ recommends:

1. To spread the legs as little as possible.

2. To arrange an elastic fixation of the pelvis by Esmarch's bandage.

3. When possible, to await spontaneous delivery; when use of forceps is necessary, not to produce forward traction, but rather to make extensive vaginal perineal incisions. If the vagina ruptures it must not be sutured, providing the bones are well approximated.

Garrigues¶ advises the immediate repair of injuries with silk or catgut sutures. A tear in the bladder should be closed with continuous catgut tier sutures, one applied to the mucous membrane, the other to the muscular coat and the peritoneum. A vesico-vaginal fistula heals, as a rule, spontaneously.

In 44 operations of recent* date the

§L. c.

‖L. c.
¶L. c.
*Robert P. Harris, l. c.

results as regards injury to the mother are as follows:

Results as to disability.	No. of cases.	Per cent.
Perfect recovery,	5	11.4
No injury to locomotion	27	61.4
Vesico-vaginal or urethro-vaginal fistula,	4	9.1
Not stated,	8	18.1
	44	100.0

If the symphysis is divided by the subcutaneous method, leaving the soft parts intact, and then the bones are separated to the extent of 7 centimetres, it seems reasonable that the soft parts adherent to the pubic bones on either side must separate from the bones or tear. That the vagina, bladder or the urethra does not tear in every case can be explained only by the pliability of the anterior vaginal wall. Consequently it seems that to avoid serious injury to the soft parts they should be loosened by the operation from the pelvic walls on both sides far enough to allow sufficient stretch.

Prognosis.—In the case of an operation—that is, in its process of evolution—it is difficult to make out any statistics that will convey impression of the mortality. What is a low mortality to-day may be a high one to-morrow. All we can do is to collect cases and make up the mortality for different years or series or years, for different operators and different methods.

From 1777 to 1858 there are 86 cases on record. In these the mortality to the mothers was 33.72 per cent. and to the children 90.5 per cent. From 1866 to 1888 the operation was performed 76 times in Naples with a mortality to the mothers of 23. 6 per cent., and an infantile mortality of 22.4 per cent. The statistics of Morisani this year show a maternal mortality of only 3.5 per cent. and an infantile mortality of only 5.5 per cent. in 55 operations. Zweifel has operated 14 times with 14 recoveries, and 12 living children. Pinard has operated 20 times with one death. Neugebauer has collected all symphysiotomies on record up to date, 196 cases, with 23 deaths, of which 4 were not due to the operation—making a mortality of 10 per cent.

Varnier, in 124 modern operations, has found a maternal mortality of 9 per cent. and an infantile mortality of 22.7 per cent.—a combined mortality of 16 per cent.

Garrigues says the operation has been performed 26 times in the United States, with a mortality to the mothers of 15.39 per cent. and to the children of 30.77 per cent.

Indications.—Until the best method of operation has been decided upon it is difficult to define the indications for symphysiotomy. The principal indication will be a narrow pelvis (flat, or generally contracted pelvis); but it may also find application, and has been used, in cases of faulty presentation of the fetal head—for instance, impacted occipito-posterior vextex presentations or mento-posterior face presentations. An absolute requrement for its performance is that the child is alive.

Symphysiotomy is naturally destined to assume a position between high forceps delivery and version on the one hand, and Cæsarean section on the other, and is a direct competitor with craniotomy and induced premature labor. When we consider that the maternal mortality from craniotomy and symphysiotomy do not differ materially (7.5

per cent. for craniotomy and 9 per cent. for symphysiotomy, with prospects of the latter being lowered), while the fetal mortality of craniotomy is 100, making a combined mortality for this of 53.8 per cent. and the fetal mortality of symphysiotomy is 22.7 per cent., making the combined mortality for this operation 16 per cent., it seems that symphysiotomy ought to take the place of craniotomy in all cases in which the child is alive.

As the life of the mother is always of more importance than that of the unborn child, *induced premature labor* will unquestionably, on account of its low maternal mortality—2 per cent.—still be preferred to symphysiotomy in most cases where the diagnosis of narrow pelvis is made during pregnancy. The high fetal mortality of induced labor—35.5 per cent.—will, however, make symphysiotomy more and more preferable the more its maternal mortality is lessened. Pinard already advocates that a woman with a conjugata vera of 7 to 9 centimetres be allowed to wait till full term and then symphysiotomy be performed. It is also probable that symphysiotomy will encroach somewhat upon the territory of other obstetrical operations. It was originally introduced to take the place of Cæserean section, and undoubtedly should do so in all cases where the length of the conjugata vera will permit delivery of a living child by symphysiotomy. Its usefulness in this direction may be somewhat extended by combining it with premature induced labor. It will also probably take the place, to some extent, of difficult high-forceps deliveries and versions. Pinard, Eustache and Garrigues consider symphysiotomy preferable to forceps application and version in narrow pelves.

As to the mathematical limits for symphysiotomy, they can be figured out for a child of normal dimensions. As the biparietal axis of the head is 9.5 centimetres, and we can depend on a gain of 2 centimetres by the symphysiotomy and 0.5 centimetres by compression of the head, a conjugata vera of 7 centimetres will be the minimum limit for the operation. The maximum limit, according to most authors, should be placed at a conjuguta vera of 9 centimetres for a flattened pelvis, and a maximum limit for a generally contracted pelvis of 10 centimetres. Morisani places the minimum limit at 6.7, Zweifel at 6.5, and Leopold at 6.0 centimetres.

Of 40 modern symphysiotomies the conjugata vera ranged as follows:

Conjugata vera,	60-64 mm.	3 cases.
" "	65-69 mm,	5 cases.
" "	70-74 mm,	15 cases.
" "	75 79 mm,	10 cases.
" "	80-84 mm,	4 cases.
" "	85-89 mm.	0 cases.
" "	90-94 mm,	1 case,
" "	95-100 mm,	2 cases.

The biparietal diameter of the fetal head was as follows:

Biparietal diameter of fetal head,	85-89 mm, 5 cases.
" " " "	90-94 mm, 11 cases.
" " " "	95-99 mm, 6 cases.
" " " "	100 mm, 1 case.
" " " "	110 mm, 1 case.

The difference in length between the two is shown in the following table:

Difference between the length of the biparietal diameter of the fetal head and conjugata vera, 12-14 mm, 3 cases; 15-19 mm, 6 cases; 20-24 mm, 8 cases; 25 29 mm. 5 cases; 30-33 mm, 2 cases.

Symphysiotomy, since its resurrection, has obtained remarkable results and has gained numerous advocates in the different countries, and its general adoption

by the medical profession as a legitimate obstetrical procedure seems to be only a question of time. Its adoption would necessitate a more general use of the pelvimeter and thereby insure a more rational midwifery than exists at the present time.

The general rules for the selection of obstetrical operations, as modified by the adoption of symphysiotomy, could, I believe, be formulated about as follows:

Length of conjugata vera, Child living: 10.5-9 forceps or version; 9-7 induced labor or symphysiotomy; 7-5.5 Cæsarean section, or induced labor combined with symphysiotomy; 5.5-4.5 Cæarsan section; 4.5 or less, Cæsarean section.

Child dead: 10.5-9 Craniotomy; 9-7 Craniotomy; 7-5.5 Craniotomy; 5.5-4.5 Craniotomy; 4.5 or less, Cæsarean section.

These are, of course, only general rules, modifications of which would be allowed in individual cases. The subcutaneous method of operation should, I think, be preferred, as it causes less hæmorrhage, is less of a lesion, is better adapted to asepsis, and as the field of operation can easily be laid open, should the necessity arise.

70 State Street.

THE OPERATIVE TREATMENT OF HÆMORRHOIDS.

The papers recently published by Lang and Whitehead, in which they published simultaneously the results of an operation very similar in its character which each, unknowingly, had performed, leads Sendler (*Centralbl. fur Chir.*, 1893, No. 34) to report the operation as he has performed it for some time past, with a *resume* of some of his cases. He performs the operation as follows: After the usual preparations, the chloroformed patient is put into the lithotomy position; the pile is drawn down, a cut made in the skin opposite to the pile mass, which is then dissected up from the loose cellular tissue; it is then cut free through sound mucous membrane, the sphincter being carefully avoided, and after hæmostasis the mucous membrane is united to the sound skin. If the pile is a large one, or there are many, it would be well to proceed, step by step, and after the extirpation of each pile immediately place the sutures. His after-treatment consists in the insertion of a drainage-tube covered with iodoform gauze and an antiseptic dressing; when, by means of a simple diet and opium, the bowls are confined for five or six days and then are only slightly moved. Generally after eight days the stitches can be removed and the patient can get up. His shortest cure was four days, the longest twenty-one days, or an average of fifteen days in bed. There was very slight pain after the operation and no untoward symptoms. He lost no patients. All of his cases had been under observation for some time, and in none does he find any difference from normal in the functions of the spincter or rectum.

He claims for the operation speed and certainty, with no granulating surfaces of any moment, and a perfect functional recovery.—*The Amer. Jour. of the Med. Sciences.*

Doctor—What have you been taking?

Patient—I have tried several bottles of "Smith's Miraculous Liver Encourager."

Doctor—You are going to kill yourself taking all kinds of quack medicines. What do you suppose we doctors are for?—*Texas Siftings.*

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BALTIMORE, FEBRUARY 24, 1894.

Editorial.

THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA.

The Medical and Chirurgical Faculty of Maryland has just cause to feel proud of the achievements of the Medical Society of the District of Columbia. This latter society is the lineal heir of the Faculty. Twelve members of the Faculty were among the organizers of the Medical Society of the District, and the plan of organization of the latter was moulded after that of the former. The District of Columbia being originally a part of the territory of Maryland, it was but natural that our State institutions—educational, social and domestic—should have made their impress upon the affairs and institutions within the District. This was especially a natural conclusion seventy-five years ago, when the population of the District numbered less than twelve thousand people. The rapid growth of the Capitol in wealth, population and in national prominence, has removed many of the ties which bound the District to Maryland, but when we come to institutions which are more permanent in their characteristics, the law of heredity is very marked.

We have, therefore, peculiar cause for pride in the success and progress of the Medical Society of the District, and we may rejoice in the good work this Society has done and continues to do for the profession of the District.

On the 16th of February, 1819, the charter of this Society was granted by a special act of Congress. From that day to the present its work has been onward, upward and continuous, keeping pace with the nation's marvellous progress in literature, art and science.

The members of the Medical Society of the District have justly appreciated the good work and good influence which their organization has exercised over professional and public interests within the District, and they have commemorated these facts by celebrating the 75th anniversary of the founding of the Society in a way to perpetuate the record of the past and to stimulate progress in the future. The distinguished gathering and the charming exercises held on the evening of February 16th may be recalled by future historians of the Society with pride and intense interest.

The address by the President, Dr. Busey, was a chaste and scholarly review of the relations of the medical profession of Washington with her early development and present prosperous condition, while Dr. Parvin, representing the College of Physicians of Philadelphia, extended appropriate congratulations and

cordial greetings from the senior medical societies. The addresses by Drs. W. W. Johnston, J. Ford Thompson and T. C. Smith were valuable contributions to the study of professional interests from the standpoint of the Society, of the hospitals and of the medical schools of the District. Such material has not only a present value, but a future use. The struggles and triumphs of professional work are the daily experiences of individuals as well as of medical institutions. We see the force of character, of energy and of application in these reminiscences of our predecessors. We can not too greatly prize their influence upon our present work and progress, and their bearing upon the history of the future.

The social reunion at the Arlington was not the least enjoyable feature of the celebration. The friendly grasp of the hand, the cordial greeting, the pleasant merriment of the hour, are important factors in the good work of our calling. They drive away care and anxiety, freshen hope and courage, and fill the heart with charity and benevolence.

He is no friend of science or humanity who discourages such influences.

THE REVISED MEDICAL LAW IN VIRGINIA.

We are pleased to congratulate the medical profession of Virginia upon the passage by the General Assembly of a bill amending and revising the law regulating the practice of medicine in that State. The bill was carefully drawn and in its present form represents the experience of the Board of Medical Examiners in dealing with the question of medical legislation. As this bill has been approved by the Governor, it now becomes a law, which will go into effect on November 1st of this year.

The old law made the Board of Medical Examiners to consist of 32 regular practitioners and 5 homœopaths. The present law reduces the number of Medical Examiners to 12 regulars and 2 homœopaths, a much less cumbersome, and, we believe, a more efficient working body of Examiners.

The law permits the Board to meet at such times and places as it deems best, removing former restrictions in this respect.

According to the provisions of the law, the following persons and no others will be permitted to practise medicine and surgery in the State :

First. All persons who have practised medicine or surgery in this State continuously for the period of at least five years prior to the passage of this act, but only such persons as have been assessed with a license tax as a physician or surgeon by some Commissioner of the Revenue in this State during each of the five years preceding the passage of this act shall be regarded as included within the provisions of this clause.

Second. All persons who have been duly examined, and have been awarded certificates by the Board of Medical Examiners under the acts of January 31st, 1884, March 1st, 1888, and Chapter LXXVII of the Code, or the amendments thereto, and who have also otherwise complied with the requirements of the said laws.

Third. All persons who shall hereaf-

ter receive certificates from the Board of Medical Examiners of this State, as provided by section six of this act, and who shall also, in all other respects, have complied with the provisions of the same.

Any person shall be regarded as practising medicine or surgery within the meaning of this act who shall profess publicly to be a physician or surgeon, and shall offer for practice as such, or who shall prescribe for the sick, or for those needing medical or surgical aid, and shall charge and receive therefor money or other compensation, directly or indirectly; but this act shall not apply to any midwife, dentist, commissioned officer or contract surgeon of the United States army or navy or marine hospital service in the performance of his duties as such, nor to any physician or surgeon residing in any State or Territory of the United States, or in the District of Columbia, called into consultation in a special case with a physician or surgeon residing in this State. Nor shall this act be construed as affecting or changing, in any way, the laws in reference to the license tax to be paid by physicians, surgeons and dentists.

The law is very emphatic in excluding quacks and charlatans who may come into the State subsequent to its passage and will exclude all who have not been recognized as physicians and paid the physicians' license tax during each of the five years preceding its passage. It was in dealing with this class that the old law was defective.

There can be little doubt of the fact that if the present law is enforced with justice, care and good judgment, the profession of Virginia will enjoy prosperity and harmony under its provisions. The profession of the State contains many men of ability and distinction, and as a body will hold its own with any State in the Union. It is animated by a very high and proud *esprit de corps*. It owes its present good fortune and strong position to the old law under which it has worked during recent years. Progress and prosperty will be strengthened by the new law.

Medical Progress.

THE BROMIDE OF ETHYL AS A GENERAL ANÆSTHETIC.

In an interesting historical and physiological discussion of this subject, with the report of about 500 cases in which it was employed, either alone or combined with chloroform, Hartman and Bourbon(*Rev. de Chir.*, Sept., 1893, No. 9) come to the following conclusions: It is of the greatest importance that a pure bromide of ethyl be employed; especial care should be taken that the bromide of ethylene is not substituted by mistake for it. This has caused accidents that have been attributed to the bromide of ethyl, and is dangerous for the patient. The bromide of ethyl, employed as it should be, is a most convenient, most rapid, and the least dangerous anæsthetic. The recovery is prompt and is not followed by malaise. It produces a congestion of the cerebrum, and consequently can be administered in a sitting position, and is thus employed by laryngologists. It is, however, harmless only in short operations, and can therefore only be used in such. For longer operations it is necessary to resort

to mixed narcosis, the bromide of ethyl being used at first, and then chloroform; this shortens the first stage, but does not exclude the danger of syncope. It has the disadvantage in some cases of making the patient's breath smell for a day or two of garlic, but of this he is not conscious.—*The Amer. Jour. of the Med. Sciences.*

THE DISPOSAL OF THE DEAD.

With reference to a leading article in *The Lancet*, of Oct. 14th, 1893, on the respective merits of cremation and burial as discussed at the Birmingham meeting of the Church Congress, a correspondent calls our attention to the fact that the Church of Rome has pronounced against cremation. This fact alone must cause burial to be continued as the mode of the disposal of the dead for the members of that Church. This preference for burial is shared by many members of the Established Church, as well as by those of other religious denominations, and so, while admitting all the advantages of cremation, it is perfectly clear that burial must continue as the mode of the disposal of the dead in this country for many years to come. The deaths in England and Wales amount annually to 550,000 in round numbers, this varying considerably in different years, but with an upward rather than a downward tendency, for though the death-rate decreases, the total population does not; in other words, therefore, we must make provision for the disposal every year in our various English and Welsh cemeteries and burial-grounds for the disposal or considerably more than half a million corpses. Our correspondent, who has studied very attentively the details of burial, informs us that the cost of funerals has been very greatly reduced among the upper and upper middle clases. It is found that the expenditure of £10 to £15 will allow of everything being completed in good taste and reverence, but without any excess. These sums include the usual fees for the opening of the grave, officiating minister, &c., but not the cost of the grave itself. This, however, is not a heavy item, ranging from £1 upwards, while burial in public or common graves can be secured for a few shillings. For the burial of children the expense is less, and £5 ought to be regarded as the maximum. Keeping in view the fact that burial space for more than half a million bodies annually must be ready to hand, the lesson obviously is that there should be no undue monopoly of grave space either by means of strong, durable coffins or walled graves or vaults. It is unnecessary now to attack burial on the grounds of its expense in funeral paraphernalia. Funeral reform is an accomplished fact in most parts of the kingdom, and the funerals of the past generation are almost as extinct as the dodo. One reform is, however, still needed—viz., the substitution of a simpler and more perishable coffin for the present oaken ones with brass handles and mountings, which serve only for show. The Jews have long set an example in this respect, the bodies of members of that community from the highest to the lowest being buried in plain deal coffins; but, as Mr. Seymour Haden has shown, wood of any kind is unsuitable for coffins. The "earth-to-earth" coffin, made of solidified or hardened pulp, has had a fair trial and is said to be

thoroughly suitable for its purpose, being strong enough to convey the body from the house of death to the grave, but giving way in a reasonable time after its deposit there. Medical practitioners are not infrequently asked for advice as to the details of a funeral, and the time has fully arrived when this very necessary reform should be pressed upon all those who prefer burial as the mode of disposal of their own and their friends' bodies.—*London Lancet.*

THE PERILS OF PRACTICE.

A few days ago there died at Lancaster, Mr. Robert Clark, a victim indirectly to professional duty. Our readers will remember that the reported cause of death was blood poisoning through a small blister on the nose which the deceased must have touched after he had been engaged in dressing some sores on the person of a patient. Some defect of constitutional stamina, it may be, increased in this case the ordinary effect of the conveyed poison. The statement of these facts is in itself almost as instructive as it is brief and simple. We would, nevertheless, add something to it, and especially a reminder that no degree of familiarity with disease and death should blind the practitioner to the risk which he daily runs of absorbing that which, as it is injurious to the body of his patient, is often doubly dangerous to his relatively unaccustomed tissues, exhausted, as these may well be, by the constant strain of a laborious calling. It is, indeed, much to the credit of practitioners that, like him whose untimely end we have recorded, they are commonly far more earnest in their duty of relief and healing than in that of personal concern—nay, are at times nobly wilful in their self-neglect. We do not entirely blame them. The balance of rival claims must not in such cases be too nicely weighed, but we would again impress the manifest obligation—binding, we consider—in every such case, without exception, as that above mentioned, to secure by immediate, thorough, and aseptic personal cleanliness the only guarantee of safety against contagion. It is not enough to merely wash the hands. Thorough washing, thorough scrubbing with brush, soap and water, and finally antiseptic ablution, constitute the required minimum of precaution.—*London Lancet.*

THE VALUE OF MICROSCOPICAL EXAMINATION FOR GONOCOCCI.

Neisser recommends the examination of pus for gonococci, for the following reasons:

1. It is beyond doubt that gonococci are the true cause of gonorrhœa.

2. In many cases, especially in chronic affections, with only slight subjective and objective symptom, the proof of the existence of gonococci leads us to a correct diagnosis and thereby to an effective treatment (instead of using inefficacious astringents we apply well-known antiblennorhagics, such as silver, mercurial salts, ichthyol, etc.).

3. In cases where the question arises whether gonorrhœal disease is the result of infection or is the remnant of a previous outbreak, examination for gonococci is indispensable.

4. Since in every stage we must adjust our treatment to the number of gonococci present, the search for them is necessary not only in the beginning but during the whole time of treatment.

5. In the present state of our knowledge, examination for the germs must be confined to the microscopical; bacteriological cultivation is too troublesome.

6. Where we receive positive proofs of the presence of gonococci the diagnosis is made. In negative cases caution is necessary, as it is well known that the bacteria may exist in the deeper structures, lacunæ and mucous folds in such small number that the superficial secretions under examination may be entirely free. Then it becomes imperative to excite artificial irritation to increase the number and bring them to the surface. Clinical symptoms will aid considerably in this condition.

7. In married persons the existence of gonorrhœa in one will impose on us the duty of treating the other.—*Jour. Cut. and Ven. Diseases.*

A NEW TREATMENT OF DIPHTHERIA.

Sig. Bianchini Antonio presents his method, which is based upon the antiseptic action of phenic acid. Absorbent cotton, kept constantly moistened in a 2 per cent. solution, is worn about the neck, and by inspiration—for it is a valuable antiseptic—it is carried to the diseased surfaces (pharynx, tonsils, larynx). At the same time fifteen to thirty drops of the tincture of the chloride of iron, dissolved in aromatic water and simple syrup, is given about every hour. In grave cases the affected parts are touched twice daily with the following mixture: Salicylic acid, 3; absolute alcohol, 20; resorcin, 2; and glycerine, 10 parts. By a careful examination of the urine the amount of phenic acid which is absorbed can be ascertained, and the use of the acid can be regulated. The advantages of this method are: 1. The ease of application of the remedies. 2. The action of the acid is continuous, regulated, local, and general. 3. From the first application the fever yields, but tends to again rise if the treatment is suspended. 4. The general condition improves from the beginning.—*La Riforma Medica,* 1893, No. 204, p. 647.—*Am. Jour. Med. Sciences.*

THE COMPENSATION OF COMBINED VALVULAR LESIONS.

Baccelli (*Deut. Med. Woch.*, January 11th, 1894) remarks that the general condition of the patient may be no worse where more than one valve is involved than in a lesion of a single valve. He relates two cases in illustration: (1) A man, aged 45, had acute rheumatism five years previously, but only complained of symptoms for a year past. Although physical examination showed the heart much enlarged, and both mitral and aortic orifices incompetent, yet when at rest the patient gave little evidence of anything being the matter with him. The pulse presented nothing characteristic. Disturbance of compensation in valvular lesions is a much more complicated problem than is usually believed. Thus a patient after influenza exhibits symptoms of a cardiac lesion previously silent, or in another accustomed to hard work the compensation suddenly breaks down without apparent sufficient cause. The anatomico-pathological defect does not constitute the whole clinical picture. Murmurs at times disappear, or a fully compensated mitral stenosis may apparently present signs which should be looked upon as of

ill omen, and yet they do not prove to be so. The worst damage done to the heart is when two lesions of opposite characters, such as aortic stenosis and mitral regurgitation, exist. When the lesion affecting the valves is similar, the outlook is much less serious. But because the trouble caused by the double lesion is less, it does not necessarily follow that the danger is less. Sudden syncope may occur. The real danger lies in a material and dynamic disproportion. The prognosis must be very reserved, since the capacity of compensation may cease to exist. Prophylactic measures, including the avoidance of mental excitement, too apt to be forgotten nowadays, must be attended to. Digitalis purpurea is the sovereign remedy among cardiac tonics, caffein and strophanthus being some distance behind it. Caffein, unlike digitalis, increases the heart's action. Strophanthus is used when the others fail or have to be discontinued. (2) A man, aged 51, with no history of rheumatism, and always in good health, was seized with dimness of vision, nausea, and vomiting. He showed the physical signs of mitral and aortic stenosis. Only slight symptoms existed; he had no cough or bronchial catarrh. Here a paradox might seem to exist—namely, that a stenosis of one valve was a more serious lesion than that of two.—*British Med. Jour.*

THE DIAGNOSIS OF GLANDERS IN MAN AND IN THE HORSE.

The diagnosis, mode of infection, prevalence of glanders in large studs, and the duty of horseowners to their servants and the public are matters of great importance. The difficulties of diagnosis are recognized, and in the absence of appreciable local lesion it is seen that glanders may simulate rheumatic fever, and this suggests the probability that statistics on the point are to some extent open to question. As to the mode of infection, there appears to be no room for dispute as to the possibility of glanders being conveyed by any of the usually mentioned means. The bacillus mallei has, since its discovery by Loeffler and Shütz, been the subject of much careful study. It is well ascertained that on dried discharges it retains its virulence for comparatively long periods (according to Loeffler three months). and on reaching the respiratory membrane in its dried state is capable of inducing glanders. The act of grooming horses whose skins may have become contaminated by glanders or farcy discharges is very favorable to the inhalation of the virus with fine dust,and especially so by the excessive inspiratory act which follows the noisy expiratory effort so often adopted by grooms. In a considerable proportion of glandered horses the lung alone is the seat of the lesion.

It is, perhaps, within the range of possibility that the virus inoculated at the finger may pass by the circulation to the respiratory membrane without inducing appreciable change at the seat of inoculation, but we know that the virus may be readily carried to the pituitary membrane, and implanted there by a contaminated finger.—*British Med. Jour.*

A WORD FOR THE SLEEPLESS.

Dr. J. E. Huxley, of Maidstone, Eng., thinks that he has hit upon the natural remedy for sleeplessness. It is, in brief, to curl under the clothes like a kitten, or

put the head under the wing like a hen. His detailed description of the technique is given in a letter to the *Medical Press and Circular*, when he says: "This insomnia seems to be now a universal affliction. We live wrongly; sit up late and overwork the brain, and then go to bed in an excited condition. No one seems to have hit upon the natural remedy. I think I have. People take chloral and the like at their peril, and the fatal consequence not seldom ensues. It is all wrong, for you cannot control the dose required for the exact circumstances. But try Nature's plan instead—lowering the supply of oxygen to the blood—produce a little asphyxia, limit the quantity of air to the lungs, and the heart and circulation becoming quicker, the brain loses its stimulant, and sleep follows. When you find yourself 'in' for a sleepless night, cover your head with the bed-clothes and breathe and rebreathe only the respired air. Thus you may reduce the stimulating oxygen and fall asleep. There is no danger. When asleep you are sure to disturb the coverings and get as much fresh air as you require, or, when once drowsiness has been produced, it is easy to go on sleeping, though the air be fresh. What do the cat and dog when they prepare to sleep? They turn round (generally three times) and lastly bury their noses in some soft hollow in their hair or fur, and "off" they go. They are in no danger, although it might look as if they were from the closeness with which they embed their noses."—*Med. Rec.*

GUAIACOL AS AN ANTIPYRETIC.

The *Medical News* for January 27th publishes a portion of a lecture delivered at the Pennsylvania Hospital on January 13th by Dr. J. M. Da Costa, of Philadelphia, entitled Clinical Remarks on the External Use of Guaiacol in Reducing High Temperature in Typhoid Fever and other Febrile Diseases. Dr. Da Costa thinks that the action of guaiacol is somewhat inferior to that of the cold bath as regards promptness, but he has observed that the reduction of temperature which it produces is more lasting. He thinks it preferable to the use of cold baths, particularly in cases where proper appliances for administering the baths are wanting and where from the nature of the case it is particularly objectionable to move the patient. The odor of guaiacol is an objection to its use, and this Dr. Da Costa has not yet been able to overcome. Oil of bergamot has been tried, but the odor of guaiacol overcomes that of bergamot. Cologne water and oil of sassafras also have been tried, but the best result has been obtained with oil of cloves. Guaiacol is to be rubbed upon the skin of the abdomen or thigh with a camel's-hair brush over a space previously washed with soap and water. The largest amount that has been applied at once in Dr. Da Costa's experience is sixty drops, but from the application of fifty drops he has witnessed effects that cause him to advise that rarely should so large a dose be used. Thirty drops he thinks about the average dose. The guaiacol is to be rubbed in slowly, and the surface to which it is applied need not be uncovered, for the application can be made under the bedclothing, and it is well to cover the surface with a piece of lint and with waxed paper. The dose should be proportionate to the height of the fever;

with a temperature of 103° F. it should not exceed twenty minims at the first trial. It is not necessary to rub the guaiacol in, but if friction is not used the effect is neither so rapid nor so complete. The quickest way is to paint the guaiacol on the surface and then rub it in with the hand. Five minutes are enough for the purpose. The sensation, which is not unpleasant, is likened to that produced by the application of menthol. Dr. Da Costa thinks that guaiacol is absorbed by the skin and that it is carried by the circulation to the heat centres, upon which it acts as an antithermic. Apparently its action does not involve the depression that follows the use of antipyrine, phenacetine, and other remedies belonging to the coal-tar products. Moreover, it produces less sweating. In no instance under Dr. Da Costa's observation was there any albumen in the urine or any sign of kidney irritation detected that could be imputed to the use of guaiacol; nevertheless, he advises close examination of the urine in all cases in which the remedy is used.—*N. Y. Med. Jour.*

BACTERIA IN HUMAN MILK.

Ringel (*Münchener medicinische Wochenschrift*, 1893, No. 27) contributes the report of a series of investigations upon the bacteria found in human milk. Various observers had reported having found the staphylococcus aureus and albus, as well as the streptococcus, both in healthy milk and in that from mothers suffering from puerperal fever. Escherich examined 25 women. Of these, 24 specimens were sterile and 1 contained bacilli. He again examined 13 with puerperal fever, and found staphylococcus in 12; 4 being of the white and yellow variety intermixed; 8 the white only, and 1 of an uncertain form. Cohn and Neumann experimented on 43 cases of milk from healthy women, and found 36 containing staphylococcus albus, 1 staphylococcus aureus and pyogenes, 3 staphylococcus pyogenes albus and streptococcus pyogenes; in 2 all the above forms were united.

The writer made a series of investigations, drawing and using milk from the deeper parts of the breast only, the experiments being made under the strictest antiseptic precautions. The milk was taken from 12 healthy and 13 unhealthy patients.

The results were as follows: 3 specimens were sterile; 17 specimens contained staphylococcus pyogenes albus; 2 specimens contained staphylococcus pyogenes aureus; 1 specimen contained staphylococcus pyogenes albus and aureus; 2 specimens contained staphyloccocus pyogenes albus and streptococcus pyogenes.

An examination of the mouths of nursing infants revealed corresponding bacteria in their secretions.—*Am. Jour. Med. Sciences.*

Medical Items.

The Kentucky School of Medicine, of Louisville, is about to add a handsome and capacious new building to its equipment.

Of a total of 800 students now on the register of the University of Utrecht, 326 belong to the Medical Faculty. In 1893 the degree of Doctor of Medicine was conferred on five candidates.

Rumor has it that there is already organized a new post-graduate school in New York. It is in connection with the German West Side Dispensary, a heretofore modest institution on West Thirty-eighth Street.—*Med. Record.*

Dr. Harrison Allen has been elected Professor of Laryngology and Rhinology; and Drs. A. L. Vansant and Walter J. Freeman, Adjunct Professors of Laryngology, in the Philadelphia Polyclinic. Prof. A. W. MacCoy will continue to give clinical instruction in the same branch, at the dispensary of the Pennsylvania Hospital.

Germany, whose population is about 50,000,000, had 21,621 physicians in 1893, against 20,500 in 1892; that is, an increase of 1,521. That makes about 4.37 doctors for every 10,000 inhabitants, but they are not equally divided throughout the Empire; for in some regions there are not even two doctors for every 10,000 inhabitants, while in other districts there are 30 of them for the same number of population. Germany possesses also 915 dentists and 4,988 druggists.

The Committee of the Association of American Medical Colleges met in Chicago on February 7th, for the purpose of discussing the practicability of adopting a four years' course of study.

After much discussion the following resolution was adopted:

Resolved, That this Committee recommend to the Association of American Medical Colleges at its next meeting in June, to be held in San Francisco, that no medical college shall remain or become a member of the Association that does not provide either for a three years' course of eight month's study or for a four years' course of not less than six months each, to take effect in 1895.

The *Cincinnati Lancet-Clinic* rejoices in the fact that a professor in the Medical College of Ohio invited one of the Miami College professors to be present in the arena with him during a lecture hour. This is regarded as a kindly personal feeling between two gentlemen holding the same chairs in rival schools and an omen of better days to come, when there will be an exchange of lecture hours by gentlemen connected with separate schools.

This manifestation of good feeling is certainly more creditable than the secret and underhand cut-throat methods which are often practised by rival schools in the same city.

The Lyman prize, established for graduates of the Boston City Hospital, of not more than three years' standing, by Mrs. George H. Lyman, in memory of her husband, Dr. G. H. Lyman, who was a member of the medical staff of the hospital for many years, has been awarded this year, in two equal parts of one hundred and fifty dollars each, to Dr. John Lovett Morse, of Boston, for an essay entitled A Bacteriological Study of Four Hundred Cases of Inflammation of the Throat in Diphtheria and Scarlet Fever, with Special Reference to Pathogenesis; and to Dr. Arthur Howard Wentworth, of Boston, for an essay entitled A Study of the Blood in Early Life. The usual prize is $150, but no prize was awarded last year.—*Boston Medical and Surgical Journal.*

A story recalling a characteristic trait of the late Sir Andrew Clark is told by a correspondent of the *Daily News*. The correspondent writes in reference to the statement in the *Strand Magazine* that "as regards fees Sir Andrew Clark always took what was offered." This statement, says the correspondent, conveys a false impression. Sir Andrew always took what was offered when it was less than his ordinary fee, but not when it was more. Then an illustrative case is mentioned with regard to the physician's visit to Cannes some years since. On returning to London the patient he went to see sent him a check for £6,000, which Sir Andrew returned, saying he could not accept it, as it was excessive, his fee being £750, not an excessive sum, considering it took him away from his practice for a week. The patient paid the fee and returned the first check, asking Sir Andrew to employ it for the benefit of the suffering sick poor, a wish which, it is needless to say, was faithfully carried out.—*Med. Rec.*

Ohio has a law regulating the practice of veterinary surgery, requiring all veterinary surgeons to be examined by a State board before being allowed to practise their profession upon horses, cattle, sheep, geese, dogs and cats. As yet, the human family has no such protection from the ignorant, unqualified would-be doctor. Ohio also has a most efficient law regulating the practice of dentistry, and forbids the practice of this profession by any but qualified practitioners. For those suffering from the most deadly and malignant diseases there if no law in Ohio to prevent the most ignorant and superstitious from pretending to practise medicine. Ohio has another law requiring all practising pharmacists to be examined by a State board before engaging in the occupation of an apothecary, but no law to prevent fortune-tellers, mountebanks, Christian scientists and faith curers from pretending to a knowledge of disease and attempting to cure virulent and contagious maladies. How long, oh, Legislators! how long must these things be in Ohio?—*Lancet-Clinic.*

The Chinese Government some time ago—on its own initiative, as we understand—decided to establish a Medical College on European lines at Tientsin, North China. The post of Director and Professor of the new institution was offered to Surgeon-Captain Heuston, F. R. C. S. I., of the Army Medical Staff. That officer has accordingly been seconded for five years, and is already on his way to China. The College has been founded for the purpose of educating Chinese subjects for the medical profession, with a view to qualifying them to fill military, naval and civil appointments in their native country. The College was opened in October last with sixty students, divided into a senior and junior class, each consisting of thirty members. The 'seniors' are those who have had some preliminary education in the English language, but all alike are studying anatomy, physiology, and the other elementary branches of the ordinary medical curriculum. Surgeon-Captain Heuston is assisted by four Chinese doctors, all of whom are graduates of the University of Edinburg. All interested in the "opening up" of China to Western civilization and science must wish well to the new College.—*British Med. Jour.*

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THE HISTORY OF THE MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA AND ITS DEVELOPMENT.*

BY S C. BUSEY, M. D., PRESIDENT.

Ladies and gentlemen: Inasmuch as the occasion which has brought us together to-night is one of those historic events which emphasize the permanency of this city as the capital of a great and powerful nation, and, following so quickly the commemoration of the centennial anniversary of the laying of the corner stone of the Capitol, identifies the history of medicine with that of the city from its foundation to the present time, I will venture to call your attention to such historic data as will establish the co incident relation of the medical profession in this city with its early history, development and present prosperous condition.

On the 9th of July, 1790, Congress passed and on the 16th of the same month Washington approved the act "establishing the temporary and permanent seat of the government of the United States on the River Potomac." In March, 1791, Washington issued a proclamation defining the limits of the new federal territory and directing the commissioners and engineer to proceed with the preparation of the plan of the government city. On the 18th of September, 1793, the corner-stone of the Capitol was laid by Washington, and on

*The Address at the 75th Anniversary, held Feb. 16, 1894.

the first Monday of December, 1800, the Congress of the United States began its first session in the Capitol in this city.

When Drs. Samuel Brown and John Crocker settled here, the territory was inhabited by a few farmers, their servants, and, perhaps, some tradesmen and fishermen. With the settlement of Frederick May, a native of Boston and a graduate of Harvard University, in 1795, medicine as a science had its beginning in the city of Washington. Others followed and in 1815 there were nine physicians and two practising apothecaries. The first associate assemblage of the physicians of this city took place in 1813, called by public advertisement, to take suitable notice of the death of Dr. Benjamin Rush, the father of American medicine, and to appropriately commemorate his life and professional services.

Perhaps prior, but certainly during several years succeeding this date, the influx of charlatans and pretenders was so extraordinary, and such injuries and wrongs were perpetrated by them upon citizens, that the qualified physicians began to consider and discuss methods of procedure and organization by which the community could be protected from such wrongs and informed of the qualifications of those fitted to practise the healing art. Those efforts culminated in a petition to Congress in 1818, signed by twenty-one physicians, for the charter, which was granted, and approved by President Monroe on the 16th of February, 1819.

We have invited you here to-night to unite with us in commemoration of that event. And, now that you know that those noble founders were animated by the highest inspiration of Christian philanthrophy and beneficence in the foundation of a medical society, which has lived through a period of seventy-five years, contemporaneous in history with the federal city and the government, you will appreciate and honor the pride we take in giving expression to our praise and gratitude in memory of those noble men on this anniversary night. From twenty-one it has grown to an active resident membership of 214, of whom but two have passed the age of allotted lifetime, and its senior in membership is a decade younger than it. I need not, then, tell you that in physical vigor and intellectual alertness it is now in the very prime of mature life.

Such youth and vigorous manhood have not always characterized its membership. The average age has diminished with time and the increase of numbers. Among the honored dead twenty-seven lived beyond three score and ten, of whom six were founders; nineteen died at ages between fifty and sixty-three years, after the date of graduation, and seven held continuous membership in this society for periods of fifty to sixty-three years.

The average age of these venerable decedents was seventy-six and one-half years, the youngest of whom died at seventy, in 1874, and the last at eighty-nine, in 1893. In the primitive era of medicine in this city and during the early history of this society the life of the general practitioner could not have been less arduous than since. Many of them began life when the practice of medicine was primitive and unremunerative in a community struggling with poverty in the development of a new city. It is true that the average lifetime of the medical is much less than

that of either the legal or clerical professions, but this general law of vital statistics fails to explain the average youth of the present membership, which represents five of the eight decades of the life history of this society. These data are somewhat phenomenal, and, perhaps, without special significance; nevertheless, they emphasize the fact that the pursuit of the art of healing is not conducive to longevity, and, while the average life of men in general is increasing, that of the medical profession is decreasing. With an average of forty-three and one-half years, and a prospective death-rate of 57 per cent. under sixty-five, the problem of life and longevity is of sufficient magnitude to command your attention. It will not do to ascribe this high death-rate during the prime of life and manhood wholly to mental worry, sleepless tire and inadequate remuneration, for these find compensation in the assured livelihood, conscious pleasure and consolation of duty well done. Whether referrable to such esthetic or to graver consideration, the time has surely come when the causes of the comparatively low average life of men engaged in the science of saving and prolonging life should be intelligently and definitely ascertained. Those few, thirteen in all, who have reached and passed the age of highest death-rate are equally sure of the inevitable, but can offer their juniors the consolation of their good wishes.

The elder May came here in 1795, five years before the transfer of the government to this city. He was a pioneer who prepared the way for others, and the founder through whose professional life the history of medicine in this city during the years antedating the organization of this society can be traced through membership to and before the establishment of the government here and continuously with its growth and development down to the present time. His son, John Frederick, was born and began the practice of medicine in this city and died a member of this society at the age of eighty, leaving a son now an active resident member. In this family the continuity of membership has been unbroken from its organization to the completion of its seventy-fifth anniversary. This society, then, claims a life-time beginning before the government at Washington and coeval with the foundation of the city on the river Potomac.

The Medical Society of the District of Columbia is the youngest of twelve medical societies in this country, now in existence, which have reached and passed the seventy-fifth year of continuous active life, and is the oldest, if not the first, scientific body chartered by an act of the Congress of the United States. Ten of its founders were natives of Maryland, four of Virginia, two of Massachusetts, two were born within the present limits of the District of Columbia and of three the nativities are unknown. In personal lineage it is confined to three of the original thirteen States, but as a scientific body it claims ancestral descent from eleven progenitors, who are present by representation with us to-night. It is, however, the natural and direct heir of the Medico-Chirurgical Faculty of Maryland.

With such an ancestry dating back to 1766, during the period of colonial discontent and strife; a foundation

springing from the noble impulses of humanity and inspired by motives of high professional responsibility; fulfilling in its corporate capacity, throughout its long life, the charter declaration to promote and disseminate medical and surgical knowledge, and keeping abreast with the progress of a science which has made medicine the handmaid of religion, do you wonder that the successors of those who gave birth to this society, now living in a community representing the intelligence, civilization, progress and power of a nation of sixty-five millions of free people, should invite you to this reunion to tell you how faithfully they have kept the promise of its founders, and to unite with them in giving thanks and praise to that Providence which rules the universe?

The period comprising the years from 1819 to 1894 has been one of marvelous progress in science, literature, art and in all that pertains to Christian civilization. The village city, with its domain of farms, scattered homes, graphic streets and avenues, "squares in morasses" and "obelisks in trees," has become the metropolis of a munificent nation, under whose supervision it has grown into a city surpassing in beauty and rivaling in attractiveness the more favored cities of both the old and new world, and holding together in one compact community a cosmopolitan population where education and culture need neither the blazonry of titular insignia, the heraldry of ancestral distinction, nor the glamor of wealth to command position and influence.

During the same period, medicine, here and elsewhere, advancing along the lines of pathological research and physiological therapeutics, has escaped the era of hypothesis and speculation and now as a science of precision and demonstration commands the respect and homage of the civilized world. Now, as heretofore and everywhere, it is foremost in charity, unselfish in devotion to the welfare of public health, magnanimous under public and private wrongs and generous to a fault in unremunerative perils and responsibilities. But even this is not the full measure of its philanthropy. The mission of preventive medicine and sanitary science will not be attained until the causes of disease are eradicated and death is limited to the ailments to which flesh is necessarily heir and the process of natural waste and decay. How soon, if ever, this may be accomplished remains with the laity. Medicine will continue the pursuit with the zeal and courage of a science which seeks the welfare of mankind rather than place and fortune. The medical is the only profession, trade or occupation which seeks, by its progressive attainment of its ultimate object, the continuous decrease of emolument.

One of the most pleasing incidents of this occasion is the present representatives of the eleven ancestral societies, the oldest of which was organized in 1766 in the State of New Jersey. This exhibition of fraternity is an examplification of that beneficent spirit which dominates the medical profession and makes kindred of us all. Honored colleagues who will follow me will tell you of its achievements in science and of its educational and charitable foundations. I have only to conclude with a few words addressed to my colleagues and juniors.

It could not have occurred before and can never occur again that the senior member will be unanimously re elected to the presidency on the forty-fifth anniversary of his membership and preside at the commemoration of the seventy-fifth anniversary of this society. Such a unique compliment cannot be acknowledged in words which will completely and fittingly convey the gratitude I feel for such expression of personal and professional regard. At the centennial reunion some one of you will stand where I now stand upon whom will devolve the duty which thrills me with pleasure to-night. In the enforced retirement which must come soon I will cherish the hope that each one and all of you may live to celebrate the golden wedding day of professional life. And in communion with the Saviour of man, who was first to heal the sick, the lame, the halt and the blind.

Dr. Busey stated that it gave him great pleasure to make the statement that he is indebted to Dr. J. M. Toner, a distinguished member of the society, for many of the historical data cited in this address.

A NEW METHOD OF EXAMINING THE KIDNEY, ESPECIALLY FOR STONE.*

BY CHARLES P. NOBLE, M. D.,

Surgeon-in-charge of the Kensington Hospital for Women, Philadelphia.

I desire to report a short history of the following case, together with an exploratory operation which I performed to enable me to examine her kidney, including the pelvis of the kidney and perhaps one inch of the ureter.

Mrs. T. S., aged thirty-seven years, mother of three children, enjoyed good health until six years ago. Since that time she has been more or less an invalid, and for the past six months she has been absolutely an invalid, unable to attend to her duties. The prominent points in the history are that she has had three well-marked attacks of hæmaturia accompanied by violent renal colic (so-called); and that, at least twice, she has passed good-sized stones, the last one coming from the left kidney. In addition to this history of violent seizures of renal colic, she has suffered frequently with milder attacks of paroxysmal pain referred to the region of the right groin, the pain being, perhaps, most acute just above the right trochanter major. Recently these attacks have been of daily occurrence, and have been brought on when she was on her feet. She is usually, but not always, comfortable when in bed, but shortly after any attempts at walking the pains come on. The sexual organs are normal, with the exception of a trifling tear in the perineum. The urine has been examined many times and has a very uniform composition. Its specific gravity has varied between 1020, 1013, and 1018; it is acid, and contains pus, bladder epithelium, and ureteral epithelium, but none from the pelvis of the kidney. The urine from each kidney has been examined separately—the urine being obtained by means of the ureteral catheter. Examined in this way it has been found that the urine from each kidney is much the same, the pathological elements it contains being somewhat more marked

*Read before the Philadelphia County Medical Society, January 24, 1894.

on the right side. This difference, however, was distinctly marked with reference to the two sides. The urine from the left kidney has always flowed through the ureteral catheter freely and regularly; that from the right kidney has not done so. Upon two occasions the ureteral catheter remained in position upward of twenty minutes, and not more than one or two drops of urine flowed out. Upon another occasion, after waiting thirty minutes with the same result, suddenly one hundred and twenty minims poured out.

Taking all the facts of the case into consideration the conclusion seemed fair that there was a stone in the right ureter, and that probably this was in the pelvis of the right kidney. Several attempts were made, both by Dr. Howard A. Kelly and myself, to pass a ureteral sound along the ureter toward the kidney. It was not possible to make the sound reach above the brim of the pelvis. It was therefore proposed that an incision be made in the loin for the purpose of examining the kidney and the upper portion of the ureter from above.

My experience in performing nephrorhaphy for movable kidney after the technique of Dr. Edebohls has taught me the facility with which *a movable kidney* can be drawn out through an incision in the loin. So far as I know, no one has ever treated a non-movable kidney in this way. It occurred to me that this might be feasible, and that at all events an attempt judiciously made could hardly be a source of danger.

Accordingly, on December 12th, I made the usual incision in the loin down to and through the peri-renal fat, exposing the lower end of the kidney. With the index finger the kidney was then separated from its connective-tissue attachments and gradually drawn down into and out through the wound, so that it was entirely outside. It was now a very simple matter to explore the kidney by thumb-and-finger pressure, and to make certain that it was in a normal condition. It was equally easy to examine the pelvis of the kidney and to determine that this contained no stone. Perhaps one inch of the ureter also was within reach.

As nothing abnormal could be felt, the kidney was replaced within the abdomen and the incision was sutured in the usual way—buried silkworm-gut sutures being placed in the muscular layer, and superficial silkworm-gut sutures in the skin. No unfavorable reaction followed this operation, and so far as the operation itself was concerned the patient made an uninterrupted recovery. Unfortunately the operation has produced no effect whatever on the symptoms, which are the same now as before it was done.

I report the case simply to bring before you this method of examining the kidney. From my experience in this case and in cases of movable kidney, I believe it will be a simple and safe matter in the hands of a skilful surgeon, who has had some experience in kidney work, to remove through an incision in the loin all non-suppurating kidneys having approximately the normal size, for the purpose of a careful examination. The procedure is certainly not one of much gravity, and when done under the conditions laid down should have no mortality. Tentatively I would recommend the adoption of this method of

exploring the kidney whenever the symptoms point to the presence of stone in the kidney or its pelvis, and when these symptoms are of sufficient gravity to invalid the patient. I feel confident that as compared with the ordinary method of exploring the kidney through the depths of the incision in the loin, the kidney itself being largely or wholly above the level of the ribs, and imperfectly palpated because of its movability, or examined by means of a puncture with an exploring needle, there can be no question of the superiority of the method proposed and herewith reported.

Upon theoretical grounds this procedure would not be applicable in cases of abscess of the kidney. Under these conditions, supposedly the kidney would be fixed and not easily separated from its connective-tissue bed. Moreover, it would be enlarged, and in addition to this there would be the risk of rupturing the pus sac, perhaps inadvertently into the peritoneal cavity.

PYOMETRA.*

BY G. WILLIAM REYNOLDS, M. D.,
Gynæcologist to St. Joseph's Hospital, Chicago.

The subject which I have selected for my thesis is, it seems to me, important because of the rarity of the disease which I am about to consider.

Pyometra is a condition which has received very scant attention at the hands of gynæcological authors in this country and abroad. Among our standard American authors the disease is not even mentioned. The case which I am about to report is the only one of its kind that I have observed during a service of thirteen years as gynæcologist to St. Joseph's Hospital, during which time I have had abundant opportunities to observe gynæcological cases, and have had the privilege of seeing the greater portion of the work of the late Drs. Gunn and Parkes, and Dr. Nicholas Senn. This fact alone, aside from the paucity of gynæcological literature upon the subject, has impressed me with the great rarity of pyometra. I have been unable to find a parallel case in the literature at my command.

The history of the case is as follows:

Mrs. J., aged 53, Irish, married, was admitted to St. Joseph's Hospital, September 23d, 1893, having been referred to the institution by Dr. C. D. Bradley, of this city. The patient has had ten children, the youngest being fourteen years of age. The menopause occurred August, 1892. In April last she complained of a bearing-down sensation in the pelvis. Her general health was good, and she was able to do her housework as usual. In June she first noticed an enlargement of the lower abdomen. Two months later the bearing-down sensation had increased and was accompanied by distress in the vagina and rectum, and great vesical irritability. She found relief from her discomfort only when lying down. There was a sense of malaise, attended with slight chills, and more or less pain in the hypogastrium. At this time she sent for her family physician, Dr. Bradley, who advised her to go to St. Joseph's Hospital and consult Dr. Senn.

On entering the hospital the patient's temperature was 98°, pulse 80 and normal. She was examined by several phy-

*Thesis read before the Chicago Gyncæological Society, December 22nd, 1893.

sicians, two of whom made the diagnosis of uterine fibroid. Through the courtesy of Dr. Senn I was invited to examine the case. A median abdominal tumor was found, which occupied the lower portion of the abdomen and extended as high as the umbilicus. On digital examination the lower segment of the tumor was felt apparently about three inches from the vaginal outlet, and imparted to the finger the impression of an edematous fibroid. The os and cervix could not be made out; on passing the finger upward I felt what I supposed to be a dilated os, but on further examination it proved to be the broad ligament which had been dragged down by the prolapsed uterus. The upper portion of the vaginal canal was filled completely, and the finger could be passed only with great difficulty between the tumor and the vaginal wall. There was at this time so much pressure upon the rectum as to cause considerable obstruction to the passage of feces. The bladder was also extremely irritable.

The interest in the case necessarily centered in the diagnosis. The physical signs revealed an abdominal tumor, which had been variously diagnosed by men eminent in the profession as fibroid of the uterus, fibrocystic tumor of the anterior uterine wall, and hematometra. The two latter diagnoses were made after the examining physicians had been informed that the disease was one of great rarity. I consider the case one of uterine fibroid, and, considering the history and physical signs, together with the meagreness of the literature upon the subject, I am not surprised at my error in diagnosis, nor at the variety of diagnoses made by others. The credit of the correct diagnosis is due to Dr. Senn, who, upon digital examination, discovered obscure fluctuation, and suspected from the age of the patient and the history of the case that there might be pus in the uterus. The suspicion was based largely upon the fact that no trace of cervix or the cervical canal could be found. The patient was placed in the dorsal position and a large Sims speculum introduced, but no cervix could be seen or found by the finger. Dr. Senn proved the correctness of his diagnosis by finding an abundance of pus upon vaginal puncture of the uterus, with a small sterilized trocar, at a point corresponding with the obliterated cervix.

On the following day an anæsthetic was administered, and the uterus was incised by means of the thermo-cautery, as nearly as possible in the normal situation of the cervix. The thermo-cautery was used to avoid serious hæmorrhage and because it would leave the opening less liable to close permanently by cicatricial contraction. More than a quart of pus escaped.

After thorough irrigation with saturated boric acid solution, a half-inch fenestrated drainage tube, about six inches in length, was passed into the uterine cavity, which was about ten inches in depth. Iodoform was used freely, the vagina packed with iodoform gauze, and the usual external antiseptic dressing applied. The dressings were changed daily and the uterine cavity irrigated with an antiseptic solution. As the uterus contracted the drainage tube was shortened. On my last examination of the patient the uterus measured two and a half inches in depth, and although there had at this time ceased to be any

discharge, a half-inch drainage tube of the length of the normal cervix was allowed to remain, in order to permit the epithelium during the process of cicatrization to extend throughout the quasi-artificial cervical canal, with a view to providing, as far as possible, a structure which would practically subserve the function of the normal mucous membrane. She left the hospital perfectly well three weeks after the operation.

It is probable that this pathological condition began at or about the time of the last confinement, at which time occurred a prolapse of the uterus and laceration of the cervix, with ectropion, followed by ulceration, cicatrization, and closure of the cervical canal. The uterus was undoubtedly in a condition of suppurative endometritis at the time the atresia developed. After the uterus had regained its normal dimensions it was proven that the cautery penetrated the anterior lip between the cicatrix marking the position of the original cervix and the healthy tissue. This certainly must have aided in keeping the opening patulous.

After thorough and exhaustive study of the literature at my command I have not been able to find a case identical with, or even strongly resembling, this one. The only case which at all resembled the one under consideration was reported by Bakowski† as a rare case of abscess of the uterus. It occurred in a woman, 65 years of age, who had had a single labor at the age of 22, followed by a vaginal prolapse which had never been cured. At the age of 40 there was an obscure history of an abortion, and some pelvic trouble developed at the age of 45. The patient's abdomen became distended and tender, and the swelling extended two fingers' breadth above the symphysis and could be plainly felt by the fingers. The cervix was atrophied and the os impervious. Bakowski was able, however, to find and to force a sound through the cervical canal. A considerable mass, which was found to be the prolapsed vaginal wall, protruded from the vulva, and this could not be reduced. The hypogastric swelling corresponded with the normal location of the uterus. Rest and poultices gave temporary relief. At the end of three weeks a fetid discharge, containing shreds of stinking material, occurred from the uterus, and a fecal fistula was suspected. Two weeks later the tumor had increased in size; the os was still impervious. A sound was forced through the tissues and entered a cavity six and a half inches long. This was followed by an escape of fetid pus mixed with pieces of uterine tissue. Under antiseptic treatment she recovered in a fortnight. The cause was supposed to be the introduction of germs through cotton tampons which the patient had herself placed in the vagina, her fingers being foul from her occupation—that of dressing rawhides.

My apology for presenting so brief a thesis is simply that I was impressed with the belief that a case of such rare interest would be more acceptable to the Society than a lengthy compilation of gynæcological literature upon some more commonplace and less practical subject. Such cases are certainly rare and present undoubted difficulties of diagnosis. The possibility of a serious mistake in diag-

†Der Frauenarzt, vii, 1892, Heft 3. Uterusabscess mit Perforation in den Cervix; Heilung. Translated in the Annual of the Universal Medical Sciences, 1892.

nosis, followed by a laparotomy for the purpose of removal of an abdominal or uterine neoplasm, is certainly worthy of consideration. There are also certain interesting etiological and pathological features which command attention. The value of exploratory vaginal puncture for the purpose of clearing up the diagnosis at once suggests itself. In case a neoplasm exist, no harm would follow such a procedure.

315 Webster Avenue.

THE TREATMENT OF SECONDARY SYPHILIDES.

Dr. Alfred Fournier believes that mercury is the specific *par excellence* in the treatment of these conditions. On the contrary, potassium iodide exercises an influence infinitely less potent. Of the mercurials he prefers, as most certain and efficacious, the sublimate and the protiodide; the former being especially reserved for tertiary manifestations, while the protiodide is better adapted for the conditions under discussion. The doses should be average ones, and indeed active, as one and a half grains for a man, a quarter of a grain less for a woman. Although in these conditions choice can be made between exclusively general and local treatment, reliance should be placed chiefly upon the former, although both are useful. The general treatment is directed not only to the lesion but to the disease as well; it for the present cures and for the future is a safeguard. If the general treatment alone suffices it is useless to impose upon the patient the external treatment. If in certain forms the internal treatment is impotent to cure rapidly, then external methods can be resorted to for relief, and to destroy at the same time the active centres of contagion.—*Revue generale de Clinique et de Therapeutique*, 1893. No. 35, p. 545.—*Amer. Jour. Med. Sciences.*

LAROR AND HEART DISEASE.

Tarnier (*Jour. des Sages-Femmes*, January 16th, 1894) notes that in heart disease all great and sudden efforts put the patient in peril, and labor is no exception to the rule. Running upstairs, racing to catch an omnibus, or train, and sexual intercourse may all cause fatal syncope. The danger of labor is not special in this sense; it is dangerous in heart disease simply because it involves much effort. Tarnier induced premature labor in a lady who was subject to advanced heart disease. Notwithstanding all precautions, she became moribund in the course of the labor. Directly she died, he turned and delivered a live child, which survived. A woman was brought into Tarnier's wards in January, 1894, in labor, with advanced heart disease and asystolism; she was apparently dying. Immediately about 300 grammes of blood were withdrawn, and the symptoms of suffocation diminished. The patient grew calmer. As it was extremely advisable to bring on labor quickly, as the forceps is apt to fatigue the patient, and as, in particular, the child was dead, the basiotribe was applied and delivery effected. A few days later the mother was doing very well.—*British Med. Jour.*

The truly great physician is one who never speaks ill of his medical brother. He is dead.—*Medical Record.*

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BALTIMORE, MARCH 3, 1894.

Editorial.

THE ABUSE OF MEDICAL CHARITIES.

The amount of medical charity in this city is in excess, and much of it is unnecessary.

We hear from time to time much complaint, upon the part of physicians, of this abuse.

It is argued that we have too many dispensaries, and a want of regulation of those who apply for free medicine and treatment. If only the deserving poor were looked after, no possible objection could be made, but there is good ground for the statement that many who are undeserving of gratuitous medical service apply to dispensaries connected with medical institutions simply because they feel that they can get skilled treatment without having to pay for it.

These people impose upon the institution as well as upon the medical staff in attendance, and at the same time an injustice is done to the general practitioner, whose business suffers in consequence of the existence of these public institutions. If the dispensary degenerates into a public medicine shop where any and every one who wishes to do so can obtain gratuitous service, what shall we say of our hospitals, which are developing their work along the same lines? Formerly patients were treated in their own homes and paid their medical attendants. Now it is becoming the fad to go to some institution and pay a weekly board bill with medical service thrown in. Both the profession and the laity are being told by some eminent specialists that such and such results can only be obtained in the hospital and that home treatment is either very hazardous or sure death. These statements are often made with selfish ends in view, and without regard for morals or facts.

We do not dispute the great value of hospital treatment nor do we deny the importance of having an operative case under the very best possible surroundings and advantages. What we do protest against is reckless assertion and wholesale exaggeration of facts and conditions, the false alarm, and the imposition upon the public as well as upon the profession by misrepresentations. To assert that a minor, or even a major operation, cannot be performed in a home of comfort and with good hygienic surroundings may or may not be false, depending entirely upon the character of the trouble, and the circumstances peculiar to the case, but to assert that a simple plastic operation involving no important organs or tissues requires that the walls of a room in a private house should be scraped and whitewashed, the floors scrubbed with

antiseptic washes, the attendance of several nurses and the detail and minutiæ of an abdominal section is an unwarranted assumption of authority, and a misrepresentation of facts. Such assertions are made with one of two objects in view, either to force the patient to go to an institution or to exaggerate the importance and danger of the procedure in the minds of the patient and friends.

Such methods pay in dollars and cents, but what shall we say of the man who employs them? Is he honest, truthful or trustworthy?

We can well understand the feelings of disgust and displeasure with which the great body of medical practitioners begin to view these questions of dispensary and of hospital abuse.

Medical charity is on the increase. It is becoming more and more a disgraceful evil which a few men and a few institutions foster at the expense of a great body of fellow-workers.

We should call a halt and, if possible, try to regulate a system which is designed to build up and not to tear down the scope of true charity.

ACTIVITY AND OLD AGE.

It is a familiar saying that a man is no older than his bloodvessels. Degenerative changes set in early or late in life according to varying circumstances. A man at thirty may be older in his tissues and organs than one at eighty and, therefore, less capable of physical and mental labor. Hereditary influences largely determine the approach of degenerative changes, but one may hasten or postpone the influence of heredity by habits of life, occupation and conditions of environment. To measure a man's capacity and strength by years is often a fallacy.

Old age begins early or late according to individual characteristics. The individual must be judged largely by his characteristics.

The world's history has shown illustrious examples of precocity and early decay.

Alexander the Great was a matured commander at 21. He died before the age of thirty-five from degeneracy and debauchery. Napoleon reached the full measure of his powers before he had reached the age of thirty. At forty he began to show evidences of degeneration. The reverses which overtook him before his fiftieth year have been attributed to physical and mental inactivity.

In contrast with these examples of precocity and early breakdown, Mr. Gladstone has been held up as an example of a remarkable old age, and its activity for physical and mental work. At the age of 84 Mr. Gladstone continues to enjoy good health under great strain and responsibility. The secret of Mr. Gladstone's powers has been very clearly stated by his late physician, Sir Andrew Clark. Sir Andrew Clark has asserted that Mr. Gladstone is a man of marvelous physical and mental endowments and that notwithstanding his advanced years he has in many respects the freshness, elasticity and vigor of youth. His muscular and arterial systems are both extraordinarily well preserved and the versatility of his nervous powers are far beyond those of an ordinary man in the prime of life. He has acquired by experience and as a result of balance of the nervous

system, the power of sleeping long and well throughout the night. Even after the rejection of the Home Rule Bill, and the great crisis which followed, Mr. Gladstone's sleep was unimpaired and his physical condition uninjured.

Sir Andrew held that Mr. Gladstone's work is not exhausting, but restorative; it is his true stimulus and keeps him young and vigorous. For these reasons he would never advise him to relax into inactivity, even to prolong his life. The advice Sir Andrew gave was that Mr. Gladstone should limit the hours of his attendance in Parliament, to be sparing in his acceptance of social and public engagements and to avoid exposure to severe weather and fluctuations of temperature.

The time will come to every man when labor and care must wait upon degeneracy and inactivity. It is now rumored that Mr. Gladstone has determined to retire from the stress of Ministerial and Parliamentary duties. In taking this step he is but following the line of prudence and wisdom which has guided him through a long and distinguished career. Such a retirement does not imply a total breakdown, but a prudent relaxation and gradual yielding to nature's laws. In his present bodily condition Mr. Gladstone may live many years as an interested witness of public events.

A GOOD MOVE.

The Medical Society of the Woman's Medical College of Baltimore has made a movement which is to be commended for its progressive and energetic spirit. The society has been in existence ten years and during that time has done a good work in a very quiet way. It now has a total membership of 103, of which number 52 are active, 40 corresponding and 11 honorary members. As a result of a conviction on the part of the members of the society that a special medium is desirable for the publishing of the various papers, cases, etc., that come before it, the society has issued a Bulletin containing some recent work. It is proposed to issue subsequent numbers from time to time as the material accumulates and the funds of the society permit. No. 1 of Vol. I of this new and modest publication contains four neatly printed pages, folio size. The matter has been selected with care and is made up chiefly of reports of cases and of abstracts of lectures and papers read before the society.

The Bulletin contains no advertisements to swell its pages, and whilst making no claims to journalistic proportions, is in many respects more worthy of respect than many larger and more pretentious publications. The effort is worthy of encouragement.

THE LEGAL STATUS OF TUBERCULOSIS.

The advance which has been made in recent years in the study of preventive medicine has given a very decided stimulus to reform in municipal and State laws looking to the suppression of infectious and contagious diseases.

A very decided movement has been inaugurated in different localities to have tuberculosis included among diseases officially declared contagious. This movement has been successful in several cities. The contagiousness of tubercu-

losis has been accepted by many and denied by some. So far the question is not definitely settled to the satisfaction of all. A long and interesting debate recently took place before the College of Physicians of Philadelphia, which throws much light upon this subject. Some months ago the Philadelphia County Medical Society passed a resolution petitioning the Board of Health of Philadelphia to include tuberculosis among diseases officially declared contagious. Whilst this resolution was adopted, some of the members of the Society appeared before the Board of Health and protested against the action of the Society on the ground that a vote of a majority at a meeting of 49 members did not represent the sentiment of the 600 members of the Society.

The College of Physicians, many of whose Fellows are members of the County Society, took up the discussion thrown down by the County Society and after a very animated debate passed resolutions against a compulsory notification and opposed to registration. The College simply petitions the Board of Health "to take no action except the insisting upon proper disinfection of the rooms in which consumptives have lived and died, when it appears that such disinfection will not otherwise be carried out."

The questions raised in the discussion related chiefly to the contagiousness of tuberculosis.

Dr. J. M. DaCosta held that whilst admitting the contagious nature of tuberculosis, it was nevertheless so feebly contagious that to rank it in the same category with diphtheria, smallpox and typhus fever would be to excite an unnecessary alarm in the community and to render the unfortunate subjects of the disease objects of aversion and suspicion. The precautions against infection proper and possible, he held, were so simple that each physician could and should constitute himself health officer in the case of his own patients. He admitted the hereditary influence, and argued that the one measure best calculated to stamp out tuberculosis was to prevent the marriage of tuberculous patients. Similar opinions were expressed by Dr. Osler and Dr. Tyson.

It must be admitted that the tubercular subject has rights which society is bound to respect. We doubt whether high tariff measures can be enforced, even in Pennsylvania, with any degree of justice or consideration for this unfortunate class.

Medical Progress.

TREATMENT OF PRURITUS.

In the discussion of a paper on this subject by Bronson a number of interesting points are brought out. Bronson held (*Journal of Cutaneous and Genito-Urinary Diseases*, vol. xi, No. 135) that the underlying condition of pruritus is hyperæsthesia, hence the prime indications in the treatment are to allay or annul excess of nervous excitement. Measures to remove local excitants include such as directly tend to prevent scratching. To admonish the patient to restrain from this is usually of little avail. Restraint may be possible during waking hours, but at night, when the trouble is always at its worst, and especially during the state of somnolence

midway between sleeping and waking, no power can prevent it. It can only be avoided by first mitigating the lesion through the aid of antipruritics. Sedatives, when used internally, are apt to be disappointing, and indeed after their use general hyperæsthesia is usually exaggerated. Narcotics are especially objectionable. Bromides are often indispensable and may be required in full doses. To avoid the weakening effects of insomnia, sulphonal or some other hypnotic is occasionally needed. In addition, two internal remedies are worthy of mention; these are cannabis indica and gelsemium. Carbolic acid, characterized by Unna as the opium of the skin, is the most useful antipruritic agent possessed by the dermatologist. The following antipruritic oil is warmly commended, and it is stated that it never causes any result more serious than a trifling dermatitis:

℞.—Carbolic acid . . 3i;
Liquor potass. . 3i;
Ol. lini. . . . 3i.

Sig.—Shake before using.

A drop or two of the oil of bergamot will cover the linseed oil. Salicylic acid and salol act much as does carbolic acid. Thymol is often valuable, but also is irritating to sensitive skins.

Pruritus hyemalis is prevented by guarding against cold, since the sole cause of this distressing affection is lowered temperature.

Hyde, in commenting upon these conclusions of Bronson, stated that he has long since dropped cocaine, since it is extremely liable to develop the habit. He alluded to two methods of treatment, both of value. The first consists in exclusion of air. Thus some of the successful pastes depend for their beneficial effect upon this action. Another method of relieving pruritus, when it is circumscribed and strictly limited to one side of the body, is in treating the other and corresponding side with substitutive stimulants. A case is narrated in which a patient had long suffered from an almost intolerable pruritis of one leg Relief was obtained only after stimulating the other corresponding side of the body. Hyde called attention to gout as a frequent cause of pruritus. Next in importance he names diabetes.

Corlett states that in prurigo hyemalis the internal administration of ichthyol has apparently given him excellent results. He applies lanolin to the skin locally after the surfaces have been bathed. Resorcin has given better results than any other drug. This is used in the strength of three to five per cent., and is applied in aqueous solution.

Morrow condemns the use of gelsemium, and states that he has had excellent results from the employment of the hot-water bag applied to the spine. Indeed, he lauds this treatment above all others in certain obstinate cases occurring in people. Among the local remedies he has had the best results from a combination of carbolic acid and camphor. He uses this in the strength of one and two drachms of each drug to the ounce of zinc ointment. Another excellent remedy is salicylic acid made up in the form of wax and spermaceti, in the form of an ice, or in rose-water in the form of a solution.

Hardaway states that, in addition to the remedies already mentioned, there

are three drugs which he gives with sometimes successful results. These are quinine in 10 or 15 grain doses at night, wine of antimony given in divided doses during the day, and pilocarpine by the mouth or hypodermically, especially where the skin is harsh and dry. He holds that carbolic acid as a local application stands at the head of the antipruritics, but prefers to have it sprayed on by means of an atomizer.

Denslow calls attention to the value of ergot.—*Therapeutic Gazette.*

THE PALLIATIVE TREATMENT OF CANCER OF THE CERVIX UTERI.

Prof. M. Sanger says (*Centralbl. f. d. ges. Therapie*, Jan., 1894):

Despite the more perfect operative technique of the present day, a notable increase in the percentage of permanent cures of uterine cancer cannot be demonstrated. By means of the galvano-cautery loop, C. Braun obtained 20 per cent. of cures, but this proportion has not yet exceeded 25 per cent. This is due for the most part to the unfortunate fact that but one-quarter of the patients are fit for operation when they come under the surgeon's care.

If the disease is so far advanced that the cancer has invaded the vesico-vaginal septum, the para cervical, or even other portions of the pelvic connective tissue, palliative treatment alone is indicated either by operative or non-operative methods.

The non-operative treatment is confined to astringent and disinfectant irrigation, medicated tampons, or application of powders and caustics, as well as injections of various medicaments.

It is advantageous to precede the application of caustics by curetting. The following course of procedure is advisable: Curetting, cauterization with the Paquelin, and application of a tampon after detachment of the eschar. The tampon is prepared by moistening thin layers of cotton with a solution of chloride of zinc in water, 2 to 3.

In removal of the cervix with the thermo cautery knife, Sanger begins the incision on the healthy side. To protect the posterior vaginal wall he makes use of a broad speculum, and, for the anterior wall, of a wooden spatula. As much as can be grasped of the portio and cervix is drawn down with the forceps.

The vaginal vault then divided in a circular manner, and next the vesico-cervical septum under guidance of a catheter. The parametrium of one side, the recto-cervical connective tissue, are then separated, until the parametrium of the other side is reached. By proceeding in this manner the peritoneal folds are gradually approached. The cervix is removed by a transverse cut, and the mucous membrane of the body of the uterus cauterized as far up as possible.

Sometimes it is necessary to transfix a few spurting vessels, after which firm tamponade with iodoform is resorted to. If, at the end of fourteen days, the eschar has become detached, the zinc applications are renewed several times in the same manner. In five cases treated by this method a recurrence occurred in but one patient.—*International Jour. of Surgery.*

LAPARO-HYSTERECTOMY.

Senn (*American Journal of the Medical Sciences*, vol. cvi, No. 3), after a dis-

cussion of the indications and technique of laparo-hysterotomy, together with a report of two cases, submits the following conclusions:

1. Laparo-hysterectomy is justifiable when delivery through the normal passage is impossible without mutilation of the living child.

2. It is absolutely indicated where the conjugata vera is less than two and a half inches, when obstruction is due to fixed pelvic tumors and advanced malignant disease of the cervix.

3. Mutilating operations on a living child for the purpose of effecting delivery are no longer legitimate obstetric procedures, as laparo-hysterotomy and symphysiotomy are life-saving operations for both mother and child.

4. Hysterectomy after laparo-hysterotomy is only justifiable if the uterus itself is the seat of a life-threatening, removable disease.

5. Elastic constriction as a hæmostatic measure should not be resorted to in laparo-hysterotomy before the delivery of the child.

6. The uterine incision should be enlarged to the requisite extent by tearing for the purpose of diminishing hæmorrhage.

7. The visceral wound should be closed by four rows of sutures applied in such a manner as to absolutely arrest the hæmorrhage and completely separate the uterine from the peritoneal cavity.

8. Laparo-hysterotomy is also indicated in the operative treatment of single large myofibroma of the uterus in young women when the tumor is located within or near the uterine cavity.

In such cases the uterine incision should be closed in the same manner as in operations on the pregnant uterus, and the bed of the tumor should be packed with iodoform gauze, which is brought through the cervix into the vagina, thus serving the double purpose of a hæmostatic tampon and capillary drain.—*Therapeutic Gazette.*

REMARKS UPON THE CARE OF THE NEWLY BORN.

Dr. Hiram Woods says that there is one disease of the eye which every medical man or woman should understand: ophthalmia neonatorum. Preventable, curable, easy of recognition, it yet stands among the most prolific causes of blindness. Why? One reason is that some physicians and medical students, knowing that they will never do much, if any work in ophthalmology, pay no attention whatever to eye diseases. The eye patient is referred to the specialist. Such a practitioner, or student, in accepting an obstetrical case, feels that a duty is owed to the baby's welfare. Is ignorance, or carelessness, in watching for a disease which may cause incurable blindness, short of criminal? A second cause is the ignorance of parents. Even when proper treatment is ordered, the details are often not carried out. It is the duty of the medical attendant to know these details, follow them, and put the responsibility where it belongs, if they are neglected. I have sometimes gotten neighbors to help care for a child's eyes, when the mother or usual attendant was exhausted and a nurse could not be afforded. A third and the greatest of all causes is the midwife. The disease is seen chiefly among the poor. The lying-in woman has no other attendant than the midwife. These women often have no education,

They fail to notice the inflammation. Again, when the mother notices it, the midwife assures her it is nothing, and that a physician is not needed. The first few days are wasted, and the eyes may be lost before proper treatment is started. To meet this negligence three States, New York, Maine, Rhode Island, have enacted laws compelling midwives to report cases of mattering, red eyes, or lids, to physicians without delay. A bill is now before the Maryland Legislature. But it will do no good to have such a law if the physician, to whom the case is reported, does not know how to treat it. This, although a most important part of the subject, can be only mentioned. My object is to convince the members of the Society that it is their duty to *know how to cure ophthalmia neonatorum*, no matter what they purpose doing with other eye diseases. A few hours of neglect or wrong treatment may be fatal. In all books on eye diseases, in the 7th edition of Smith's Diseases of Children, in Keating's Encyclopœdia of Diseases of Children, are excellent accounts of the treatment. Briefly, treatment must include: 1. Cleanliness. This usually means half-hourly washing day and night. 2. The use, once daily, of a 1 or 2 p. c. silver nitrate solution applied to the inverted lids only and not allowed to touch the eye itself. —*Bulletin Woman's Med. Col. of Balto.*

DANGERS TO THE INFANT FROM FORCEPS DELIVERY.

The modern obstetric forceps is an admirable instrument, but it is well to keep in view the important fact that its use brings certain dangers to both mother and child.

Dr. Swayne, of Bristol, published a short paper in the Bristol *Medico-Chirurgical Journal* on the subject of compression of the umbilical cord during forceps delivery. He considers that this is a somewhat frequent cause of death of the infant, although the majority of text-books say little or nothing about it.

He says the result of his own statistics is that, in a total of two hundred and twenty-four forceps cases, six infants have died from cord pressure; that is, one in 37½ cases. This is only one of the several dangers to which the infant is exposed through the use of the forceps. In consideration of these facts, and having also in view certain dangers to the mother, it might be pertinent to ask if forceps delivery is not becoming too frequent in the hands of some obstetricians.

Opinions, of course, differ, and we think that there are plenty of physicians who go to extremes in either one or the other direction. The writer has in his mind one physician, with an average country practice, who had only applied the forceps once in twenty years; and, at the same time, another able country physician, with a large practice, who said that he applied the forceps in something like two out of three cases.

Which of these two is likely to have had the larger fatal mortality as the result of his methods? Probably the former, but this is by no means certain. We think that, in this country, the tendency during recent years has been in the direction of a more frequent and early use of the forceps.

VEGETABLE DIET.

Vegetable diet decreases the acidity of the urine, and increases the alkalinity of the blood. Fever does the same thing.

Suppose then that a person has a large quantity of the urates in his blood, and the alkalinity of the blood was above normal. At such a juncture he is exposed to wet and cold. As a result he becomes very feverish, and the alkalescence of his blood falls. It can no longer hold in solution the urates it contains. They are precipitated anywhere and everywhere—around the joints, in the muscles, in the pericardium or endocardium, in the cerebral meninges. Thus we have an attack of inflammatory rheumatism in its varied forms. Just think of your cold baths and alkalies! Use both, and presto, the reaction of the blood begins to become more alkaline. The uric acid is taken up, gets back into the blood again, and, by free diuresis and diaphoresis, it is washed out of the system.

If a person has a large amount of uric acid stored up in the system and begins the use of alkalies, and puts himself on a vegetable diet, the acid is dissolved and comes into free circulation in the blood. The effect of this is to make the person feel very ill. A large amount of uric acid in the blood deranges the circulation seriously, and gives rise to headaches and mental depression. This accounts for the violent headaches that so many experience in connection with a uric acid wave. The arterioles are contracted, and the circulation through the brain is decidedly deranged. Certain drugs and acid drinks will throw down the uric acid out of the blood; but at the expense of a recurrence of the rheumatic pains in the joints.

It is a well-known fact that during fasting the alkalinity of the blood falls very considerably. Any uric acid in the blood would tend to be precipitated. This fact was specially emphasized by Sir W. Roberts, a short time ago. He made it clear that, to those who are subject to renal calculi, the greatest period of danger is toward morning, when the acid wave sets in. To guard against this acid wave and the formation of renal calculi, he urges that the person should live on a non-gouty diet, should take some digestible nourishment a short time before retiring, and some alkali at bed time. For this purpose he recommends a good dose of citrate of potash in a glass of water. All this is thoroughly scientific. The alkali, in these cases, may do good or may do no good, just as it is given at the right time or not.

These cases of dead hands, where the circulation is almost arrested in the fingers, due to contraction of the arterioles, are due to uric acid diathesis. This distressing condition is an ally of gout. The great majority of those intense headaches of the migrainous type are nothing other than one of the protean forms of the same condition.—*Ex.*

TREATMENT OF SKIN CANCER.

In the discussion over Lassar's contribution upon this subject, read before the Berlin Medical Society (*Monatshefte fur Praktische Dermatologie*, Bd. xvii, No. 10), Köbner held that the cases presented by Lassar were not conclusive, since Langenbeck had presented a similar favorable result from arsenic treatment, the patient, however, perishing a year later from recidivity. In Lassar's second case the diagnosis is not assured; in the third case the patient is not fully healed. Köbner holds that arsenic and all other remedies administered by the

mouth are utterly without power, and that cure is never accomplished, excepting when the ulcer is completely removed by means of a knife in the early part of its course. Only when patients present themselves too late for operation should resort be had to medical treatment.

Bergmann gave the history of three cases in which ten, seven, and five years respectively had passed without recurrence. In considering the radical cure of skin cancer it must be remembered that cicatrization is followed by destruction of cancer cells. Such cicatrization may take place quite independently of any therapeutic treatment. Under some circumstances carcinoma will last twenty years and then undergo cicatrization. Small clusters of cells may remain latent for years. Following seborrhœa, ulcers develop which closely resemble carcinoma. Before a physician recommends internal treatment he should remember that these skin cancers frequently do not recur when thoroughly removed by the knife. Lassar, in answer to these criticisms, stated that he exhibited his patients simply to show that by arsenic treatment carcinomatous nodules in the face were prevented from running their customary course.—*Therapeutic Gazette.*

PEROXIDE OF HYDROGEN IN STOMATITIS.

Boennecken, in a paper on stomatitis (*Deut. med. Woch.*, January 11th, 1894), insists upon the importance of paying attention to the mouth during acute febrile or wasting disease; stomatitis originating in neglect of attention to the cleanliness of the teeth, gums, etc., may have a serious influence in retarding convalescence. The value of antiseptic applications is generally accepted, but the solutions of chlorate of potassium and permanganate of potassium commonly used are not sufficiently concentrated to have an antiseptic action, especially when the short time they can remain in contact with the mucous membrane is taken into consideration. Moreover, these strong solutions are apt to be painful. Boennecken strongly recommended solution of peroxide of hydrogen; it is not poisonous; does not cause pain; and has an effective antiseptic action even in solutions so weak as 2 per cent., or even less. He states that by its use fœtor is corrected in a few minutes, and that its continued use was followed by a marked improvement in the condition of the epithelium in twenty-four hours, and complete cure of even severe cases in five or six days. Leo, in the discussion which followed the reading of the paper, stated that he had also obtained very good results, but that in chronic stomatitis a solution stronger than 2 per cent. acted better. Wolters had found the peroxide in 5 to 10 per cent. solution very useful in mercurial stomatitis. Binz, however, regarded chlorate of potassium as equally effective, and observed that it probably acted in the same way as the peroxide, namely, by liberation of nascent oxygen. —*British Med. Jour.*

REPORT YOUR UNSUCCESSFUL CASES.

An attentive reader of medical literature must be struck with the almost unbroken succession of satisfactory results that it shows. Be it a new drug or a new operation, a novel method of treatment or an undreamed of instrumental procedure; in every case the results of

the discoverer are such that we are tempted to say, "Search no further. for better can't be found." Medical mankind seems to have taken Emerson's dictum for its motto: "One thing is forever good. That one thing is success." Only too often, however, do we find that the results obtained by their successors are not by any means the same as those obtained by the originators of the procedures. It reminds us of a picture we once saw of death, in physician's attire, standing in front of an elaborate sign-board upon which was painted the advertisements of remedies infallible for all diseases that flesh is heir to. "Hum," says death, "at this rate I'm afraid I shall have to go out of business; but, perhaps, it is not quite literally true; I'll wait awhile before I decide." It would be well indeed if the impulse to record failures were as strong as that to record successes; we can learn as much or more from the former than from the latter. Unfortunately it is not so, and we must make our experience for ourselves, to be of use to no one but ourselves, and sometimes hardly that. —*International Jour. of Surgery.*

CARE OF THE TEETH.

One of the most skilful dentists in New York gives these rules for the care of the teeth: Use a soft brush and water the temperature of the mouth. Brush the teeth up and down in the morning, before going to bed, and after eating, whether it is three or six times a day. Use a good tooth powder twice a week, not oftener, except in case of sickness, when the acids from a disordered stomach are apt to have an unwholesome effect upon the dentine. Avoid all tooth paste and dentifrices that foam in the mouth; the lather is a sure sign of soap, and soap injures the gums, without in any way cleansing the teeth. The very best powder is of precipitated chalk; it is absolutely harmless, and will clean the enamel without affecting the gums. Orris root or a little wintergreen added gives a pleasant flavor, but in no way improves the chalk. At least a quart of tepid water should be used in rinsing the mouth. A teaspoonful of Listerine in half a glass of water used as a wash and gargle after meals is excellent; it is good for sore or loose gums; it sweetens the mouth, and is a valuable antiseptic, destroying promptly all odors emanating from diseased gums and teeth. Coarse, hard brushes and soapy dentifrices cause the gums to recede, leaving the dentine exposed. Use a quill pick, if necessary, after eating, but a piece of waxed foss is better. These rules are worth heeding. —*Canadian Practitioner.*

Medical Items.

Dr. Richard Pretlow, a well-known physician of Covington, Ky., died February 20 from the effects of influenza.

A woman, named Mary McCusker, died at Carrigallen, Co. Leitrim, at the remarkable age of 112 years. She was ill only two days, and was sensible to the last.

The German Emperor has conferred on Professor Henoch, the author of the classical work on children's diseases, the Order of the Red Eagle, Second Class, with the crown and oak leaves.

The Pennsylvania Railroad Company has sent out a special train with two physicians, who are to go over the whole line to Chicago and vaccinate at each station all the switchmen, sectionmen, gate keepers and other employees.

The damages given to heirs for a death through the negligence of railways, etc., has heretofore never been over $5,000. An Arkansas jury, however, has just given a verdict for $20,000 against the Little Rock & Memphis Railroad.—*Med Rec.*

A Brooklyn doctor gets a column notice in the daily press for his extraordinary heroism in supplying blood to an exsanguinated patient. This is not a rare occurrence in medical experience, and one must conclude that in Brooklyn heroes are cheap.—*Med. Rec.*

In the United States between seventeen and eighteen millions of dollars are annually expended in theological education, while less than half a million is appriated to medical education. In Canada these professions are endowed, respectively, $2,100,000 and $85,000.

Dr. E. L. Trudeau, of Saranac Lake, has been given $10,000, with which to build and equip a laboratory for the experimental study of tuberculosis. He has, as well, a fund of $1,500 per year for carrying on the work. With such a scientist as Trudeau at the head we shall expect tangible additions to our knowledge of this most important subject.—*Med. Record.*

The annual meeting of the Berlin Medical Society was held on February 10th, when Professor Virchow was again elected President, and Professors v. Bergmann and Siegmund, Vice-Presidents. From the report it appears that the membership at the end of the year was 914, as compared with 889 for last year. The income of the Society was 28,000 marks, and the expenses 23,000, and the total assets of the Society amount to 90,000 marks.

Dr. James E. Wendal died at Murfreesboro, Tenn., on December 21, 1893, aged 81. He graduated from the University of Pennsylvania in 1839, and was continuously engaged in the practice until stricken down, about ten days before his death. Age had not impaired any faculty; his eye was undimmed, his hand steady and his voice clear and strong. He was actively engaged all these years, and until his last illness. He ministered to five generations of several families here.—*Med. Rec.*

We are glad to know that several of the smaller cities of Ohio have ordinances fixing a license fee for tramp quacks at twenty-five to one hundred dollars per day while stopping in such places. It should be one of the functions of all county societies in all the States to see that such ordinances are enacted by all villages, towns and cities. Concert of action on the part of members of the medical profession will bring it about. Where such laws do not exist the attention of mayors and councils should be directed to the town where these laws are in force, and they be respectfully requested to imitate the good work of those places. Active co-operative work in this direction by county societies will do the business, and no other known force or element can or will accomplish it.—*Cinn. Lancet-Clinic.*

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BREATHING EXERCISES A CURATIVE MEASURE FOR CONSUMPTION, WITH A NEW THEORY ADVANCED AS TO THE ÆTIOLOGY OF THAT DISEASE.*

BY EUGENE LEE CRUTCHFIELD, M.D.,

Life Fellow and Gold Medalist of the Society of Science, Letters and Art, of London, Eng; Lecturer on Applied Therapeutics in the Baltimore University, School of Medicine; Member of the Baltimore Medical Association; and Member of the Clinical Society of Maryland.

On Feb. 24th, 1890, it was my privilege to read before the Baltimore Medical Association a paper entitled "The Application of Vocal Culture to the Treatment of Throat and Pulmonary Affections." In the discussion which followed, one gentleman remarked that although the subject was not entirely original with me (which point I had acknowledged in the paper), it was sufficiently so for me to be regarded as a pioneer in that line. They all conceded that the question is one of vital importance and likely to prove of benefit to the practitioner of medicine in treating cases of throat and pulmonary disease. This essay was published in *Gaillard's Medical Journal* of August, 1890, and read before the Society of Science, Letters and Art, of London, Eng., on January 20th, 1891. In an article on "The Relation of Medicine and Music," Dr. Ephraim Cutter, of New York, quoted largely from my paper, giving me full credit for the extracts that he had made. His article was published in *The Medical Bulletin* (Philadelphia), of April, 1891.

*Read before the Baltimore Medical Association, on December 18th, 1893.

So numerous were the letters received after the publication of this essay, containing facts that confirmed my opinions on this subject, that I prepared a second paper, entitled "Additional Facts Regarding Correct Vocal Training." This was read before the Baltimore Medical Association on Feb. 9th, 1891; published in *Gaillard's Medical Journal*, of April of the same year; and on the 22nd of the following September was read before the Society of Science, Letters and Art, of London. These papers called forth from the pen of Prof. A. Lapthorn Smith, B. A., M. D., M. R. C. S., Eng., F. O. S., Lond., a very complimentary editorial notice in *The Canada Medical Record*, of February, 1892. This editorial was copied into the June (1892) number of *The Medical Brief*, of St. Louis. These facts have been mentioned not in a spirit of egotism, but simply to show the importance attached to the subject by the medical profession.

In these papers, the attempt was made to prove (*a*) that a proper training of the voice for both speaking and singing is prophylactic against throat and pulmonary affections and curative of these diseases if they are not too far advanced when the cultivation of the voice is begun; (*b*) that the so-called abdominal or diaphragmatic respiration is at the foundation of all correct vocal training; (*c*) that this is the only proper mode of breathing for both sexes at all ages; and (*d*) that physicians should profit by the experience of elocutionists and singers, and avail themselves of this resource in combating these formidable maladies, as they would thus relieve suffering, prolong life, and at the same time offer to their patients a mode of treatment that is also productive of pleasure, intellectual and refining in its influence.

As it is my purpose now to speak particularly of "Breathing Exercises as a Curative Measure for Consumption," it is well that I should give my reasons for holding that diaphragmatic breathing is the only correct method for both sexes. Upon this point will hinge the whole of this paper. Allow me, therefore, to quote from my first article on this subject: "1st. Animals breathe in this manner. 2nd. Children (both boys and girls) employ deep respiration up to a certain age. If proper attention is paid to their clothing, to see that their waistbands do not become too tight, individuals of the masculine persuasion continue to breathe correctly throughout life. Girls breathe in this way until the time for putting on the corset, and then farewell, a long farewell, to correct breathing and, in many instances, to the enjoyment of health. 3rd. Savages, unfettered by the restrictions of fashion, breathe through the whole extent of the lungs, allowing the diaphragm to descend and press the abdomen downward and outward during inhalation. 4th, The educated adult breathes thus—when asleep. Incidentally, I may remark that one of the best methods ever proposed for resuscitation in cases of asphyxia neonatorum is that suggested by the late Prof. Harvey L. Byrd, A. M., M. D., of this city. I have no doubt that the reason of its efficiency consists in the fact that it acts in accordance with the theory of diaphragmatic respiration."†

†See my article on Prof. Byrd's "Speedy Method" in "The Medical Bulletin" (Philadelphia), September, 1892.

Holding these views, it was extremely gratifying to me to see in the *Century Magazine*, of August, 1893, an article entitled, "Breathing Movements as a Cure," by Dr. Thos. J. Mays. The facts, the assertions, and the conclusions contained therein corroborate my own opinions on this subject. Time will not permit me to give a synopsis of Dr. Mays' paper, but there are some points to which it is important to call attention. In the first place, he has proved conclusively that the original type of breathing in both the male and the female sex is the abdominal. Through the kindness of the authorities of the Lincoln Institution of Philadelphia, he had the opportunity of investigating the chest movements of eighty-one Indian girls, using for that purpose the pneumograph. In each case he took both a costal and an abdominal tracing. While all of these girls were Indians, some of them had a large admixture of white blood in their veins. By his investigations, Dr. Mays discovered, 1st, that in full-blooded Indian girls the diaphragmatic is the only type of breathing; 2nd, that "those who showed a costal type, or a divergence from the abdominal type, came from the more civilized tribes, like the Mohawks and Chippewas, and were either one-half or three-fourths white;" 3rd, "that the costal type of the civilized female is developed through the constricting influence of dress around the abdomen;" 4th, "that the costal type of breathing is much less pronounced, or may be absent, or may even revert to the abdominal type, in those civilized women who never wore corsets, or practiced tight lacing of any kind;" and 5th, that by placing around the abdomen a broad band sufficiently tight to interfere with the motion of the diaphragm, there may be produced a modification of the chest movements of the civilized male, *i. e.*, that he will acquire the costal mode of respiration.

Dr. Mays then mentions the fact that in the majority of cases phthisis pulmonalis has its beginning at the apex of the lung. He then points out that, contrary to a common belief, males are more liable to contract consumption than females. His own researches on this point have been extensive. He shows that although "she is the weaker of the two sexes, leads a sedentary and quiet life, is engaged in indoor occupations, is subjected to the harmful influence of impure air, and is thus constantly exposed to causes which are believed to give rise to the disease," woman falls a victim to consumption less frequently than man. Then, too, statistics show that when they are employed side by side in the same occupation, man succumbs to the disease more often than woman. Moreover, we must not lose sight of the fact that woman having less lung capacity than man, a large breathing surface does not afford immunity from consumption.

Dr. Mays next combats some of the popular ideas in regard to the production and the avoidance of tuberculosis pulmonum. While he does not underrate the value of pure, fresh air, he thinks that too much importance has been attached to this point so far as the disease under consideration is concerned.

To support this view, he mentions the fact that Icelanders and Laplanders live in dwellings in which the atmosphere is of the most vitiated nature, and

yet phthisis pulmonalis is almost unknown among them. Presenting a marked contrast to these people are the inhabitants of tropical countries who uninterruptedly breathe fresh, wholesome air by day and night, among whom, however, the prevalence of consumption is wide-spread. That humidity of the atmosphere does not cause consumption is proved by the fact that Bogota, in the United States of Columbia, is entirely exempt from the disease, although the climate is very damp. To support these assertions, Dr. Mays quotes from authorities on the subject.

Putting together these facts, that consumption is not due to the causes to which it is generally ascribed, that in the large number of cases it begins at the apex of the lung, that women exercise the apex of the lung in respiration considerably more than do men, and that it is a well-known law that exercise strengthens an organ, Dr. Mays concludes that here is the secret of woman's comparative immunity from phthisis pulmonalis. I believe that there is a great deal of truth in his theory, but it seems to me that he has presented but one-half the truth. If we accept his theory unreservedly, we are at once confronted by several questions which it will be rather difficult to answer satisfactorily. Would Dr. Mays then have all persons (men as well as women) adopt costal respiration in order to secure exemption from consumption by exercising the apex of the lung? To teach this doctrine would be inconsistent, for he has proved that diaphragmatic respiration is the natural method for both sexes and we cannot for a moment suppose that the normal exercise of a physiological function is ever incompatible with health. How does he explain the occasional occurrence of consumption in women, notwithstanding the constant exercise of the apices of their lungs?

To solve these problems, I now advance a broader theory. I confess that it was suggested to me by a consideration of Dr. Mays' hypothesis, but in so far as it does not embrace his theory, it is to the best of my knowledge and belief new and original with me. I believe that whether occurring in man or woman, consumption is largely due to faulty methods of respiration. This may seem strange after what I have said in a former portion of this paper, but I will try to show that my position is not paradoxical. While abdominal respiration is the proper method and nearly all men have it, they do not have it to the full extent designed by nature. A prominent teacher of elocution in this city told me that he has repeatedly observed this. It is easy to show why this is so. During infancy, mothers and nurses are not careful enough about the bands around the little one's abdomen. They are often fastened so tight that they interfere with the respiratory movements. Meanwhile the little fellow is growing, so that the normal action of the diaphragm and the abdominal muscles is daily more and more impeded. When he becomes older, the waistband of his pantaloons acts in the same way. It may be sufficiently loose at first, but as he grows day by day he soon reaches the point when it will compress the abdomen and seriously affect respiration. Then, too, the habit of leaning forward against the desk at school modifies the respiratory move-

ments. Taking all of these facts into consideration, we need not be surprised that men do not have diaphragmatic respiration to the full extent intended by nature. If they had, consumption would be less common among them than it now is. Deep breathing employed to its full extent brings into exercise not only the lower part of the lungs, but also the apices. Any one can satisfy himself on this point.

One reason why consumption is rare in elevated or mountainous regions is that at the sea-level a cubic foot of dry air contains about 130 grains of oxygen. At an elevation of 6000 feet it contains only about 106 grains. Consequently, to supply the needed amount of oxygen to the lungs, more air must be inhaled. At first, this is accomplished by increased frequency of the respirations, but it is probable that as the lungs expand and the air enters tissue hitherto unused, the breathing becomes less hurried and approaches the normal standard. This, however, necessitates deep breathing to the full extent. This property of the atmosphere at great altitudes probably explains why Bogota is free from consumption, although the climate is exceedingly damp. It is at an elevation of 9000 feet. Therefore, deep breathing must be practiced by those residing there. We have thus seen that consumption in men is largely due to inactivity of the apices of the lungs caused by respiration not sufficiently deep. The apex thus remaining inactive, this portion of the lung becomes weak and liable at any moment to take on a low grade of inflammation. It is, therefore, unable to resist the influence of the bacillus tuberculosis, which here finds a *nidus* and sets up that dread disease, phthisis pulmonalis.

It now remains to consider why women should ever have consumption at all, since they are constantly exercising the apices of their lungs. The trouble with them is that they exercise no other portion of the lung. The apex is therefore made to do more than its allotted share of work, and the result is, it becomes tired, worn out, exhausted. In this condition it is unable to cope with the bacillus tuberculosis, which gains the victory and implants a disease that will eventually cause the death of the unfortunate individual. This being the case, the remedy is apparent. Remove the cause; *i. e.*, practice deep breathing.

My theory, then, is that in both sexes consumption is largely due to faulty methods of respiration. In one, the breathing, while deep, is not sufficiently so to bring into exercise the whole lung. The apex is allowed to remain inactive and undeveloped. In the other sex the apex is unduly taxed. It therefore becomes exhausted and readily succumbs to disease. The therapeutic measure to be employed in each case is the same. Practice the natural method of respiration. Allow the diaphragm to descend in inhalation and ascend during exhalation. Remove every obstacle that interferes with the free action of the midriff and the abdominal muscles. Let mothers and nurses be more careful about the children's clothing; let them see that that it is always loose. Let teachers discourage the habit of leaning forward against the desk in such a manner as to impede the respiratory movement. Let all garments for both sexes

be supported from the shoulders and not from the waist. Let the corset and tight belts be discarded. Lastly, let physicians instruct those under their professional care upon these points and recommend this important therapeutic measure whenever it is demanded either as a prophylactic or a curative.

In my former articles, the cultivation of the voice was recommended, but as I have said, correct breathing is the foundation stone of vocal culture. The advantages which vocal culture has over mere breathing exercises are the greater interest and the intellectual enjoyment connected with the former and the fact that the scientific use of the voice is itself beneficial in throat disorders apart from the good derived from the deep respiration. If, however, we can inculcate the doctrine of abdominal breathing and get our patients to put it into practice, we may anticipate greater results in treating consumption than have ever yet been achieved.

Dr. Mays gives in the latter part of his article in *The Century Magazine* exercises to be practiced in order to expand the lungs fully. I do not deem it necessary to describe them here, since any one that thoroughly understands the principle involved can devise means for accomplishing the end in view. Moreover, such exercises are detailed in works on this subject. They are better learned from a competent voice-builder. However, I simply wish to remark that in all the exercises given by Dr. Mays, particular stress is laid upon taking a deep inspiration, although he attributes consumption in the male to non-usance of the upper portion, the apex, of the lung. From this we can infer that he recognizes (although he fails to mention) the point that I have emphasized, viz., that deep breathing employed to its full extent brings into exercise not only the lower portion of the lungs, but also the apices.

In conclusion, I acknowledge having committed two faults. As to the first, I am like the man who wrote a book in which the capital "I" occurred so frequently that in setting it up the printer's supply of that letter was soon exhausted. This, I hope, has not in the present instance been due to egotism. Let the liberal use of the pronoun of the first person be ascribed rather to the writer's interest in the subject, which to him is so important that he has studied it carefully and exerted his influence to make it better known, thus identifying himself with the theme.

The second fault of which I am guilty is that in the preparation of this paper I have built largely upon another man's foundation. But I cheerfully acknowledge the debt that I owe to Dr. Mays. He has done good scientific work by his investigations along this line, for which he merits the gratitude not only of the medical profession, but also of humanity in general.

Appendix.—Since the reading of this paper before the Baltimore Medical Association my attention has been directed to a valuable *brochure* entitled "The Suppression of Consumption," by G. W. Hambleton, M. D., President of the Polytechnic Physical Development Society of Great Britain.‡ Before this was brought to my notice I was entirely ignorant of Dr. Hambleton's researches. That writer argues that "consumption is the direct

‡Published by N. D. C. Hodges, New York, 1890.

result of the reduction of the breathing surface of the lungs below a certain point in proportion to the remainder of the body, and is solely produced by conditions that tend to reduce the breathing capacity."

While this theory is similar to mine, the two are not identical. And just here it is proper to say that it has been known for a long time that deep breathing is beneficial in the treatment of phthisis, and that in my first article I acknowledged that the subject was not entirely original with me. Therefore, it was with extreme satisfaction that I learned of Dr. Hambleton's investigations. His success in combating this formidable disease furnishes additional testimony to the truth of my views. A few words in regard to his theory are necessary: 1st. Consumption is not caused by a "reduction of the breathing surface" so much as by the non-usance of certain parts of the lung, for as Dr. Mays has pointed out, woman's comparative exemption from this disease, although she has less lung capacity than man, proves that a large breathing surface does not afford immunity from tuberculosis pulmonum. 2nd. His theory does not explain why men (who do not exercise the apex sufficiently) often contract consumption, and women (who tax that portion of the lung too much) sometimes succumb to that affection. It does not reconcile these two facts. 3rd. Notwithstanding the plain statement embodied in his theory, he attaches great importance to pure air and other hygienic surroundings, ignoring the facts mentioned by Dr. Mays in regard to Icelanders, Laplanders, and residents in tropical climates. 4th. Although he believes so firmly in the "reduction of breathing surface" as the *sole* cause of consumption, in the treatment he relies to a great extent upon tonics, clothing, outdoor exercise, and suitable food. In formulating my theory, the word *largely* was used. 5th. Although in the treatment he recommends deep breathing, he does not dwell sufficiently upon the absolute necessity of employing this mode of respiration because it is the physiological method, nor does he point out the fact that it is the natural process for women as well as for men. Thus it will be seen that while Dr. Hambleton's theory and mine both call attention to the value of respiratory exercises in the treatment of consumption, the two are not identical.

1601 Eutaw Place.

TWO CASES OF FRACTURE OF THE CERVICAL VERTEBRÆ.*

BY JAS. J. CARROLL, M. D.,

First Assistant Resident Physician of the Maryland University Hospital.

It is said that "misfortunes never come single-handed, but in battalions." Well, something similar is often observed in the practice of medicine. Rare cases of gravity come to us, not exactly in battalions, but frequently in twos, threes or perhaps in fours. We had such an occurrence at the University Hospital during October, in which month were admitted two cases of fracture of the cervical vertebræ.

Oliver Dugent, a bricklayer, weighing fully 200 pounds, fell a distance of 25 or 30 feet and struck upon his head and left shoulder. He was brought to the

*Read before the Medical Society of the University of Maryland, Feb. 6, 1894.

hospital at 3 o'clock in the afternoon of October 30. There was a bruise on the top of his head and on his left shoulder; also a contusion of the left knee and left ankle. Patient was perfectly conscious and made frequent inquiries as to the extent of his injuries. His sole complaint was much pain about the neck, and of numbness of the body. The head was slightly extended backwards and pain was felt in the cervical region whenever any change of the body caused the slightest movement of the head or whenever pressure was made upon the neck.

There was inability to cough or to forcibly expire. There was no thoracic breathing, respiration being entirely abdominal. The toes would move in response to tickling the soles of the feet. Motion was completely lost in both upper and lower extremities. Sensation was absent from a point about 2 or 3 inches below the clavicles down to the toes, and dorsally from the spines of the scapulæ down. It was absent also in the forearms and hands, but a little sense of feeling was retained in the arms. Urine was drawn, which flowed lazily at first and later on only by spurts with each act of inspiration. There was no albuminurea. Pupils were about the usual size. Priapism was noticed about ½ hour after patient's admission into the hospital. Temperature was below 95, pulse 68, and respiration 18. Some whiskey was given by the mouth, and notwithstanding the extensive motor paralysis it was soon regurgitated, the usual strain of vomiting not being noticeable. Although the area of sensation on the surface of the body was extremely limited, yet he could feel that he was going to vomit, and asked the attendants to provide a basin. He slept pretty well the first night with short intervals of waking, at which time he would invariably call for water.

Oct. 31, neck was still very sensitive. Patient lay with eyes closed most of the time, but would quickly and intelligently reply when spoken to. Thirst was quite marked. On account of inability to urinate, catheter was used, urine drawn and examined. It was rather red in color, acid in reaction, contained no sugar, no albumen, no bile and had specific gravity of 1030. Cremasteric reflex was obtained on left side but not on the right. Morning temperature was 100.1-5, pulse 80, respiration 20. Evening temperature 103, pulse 88, respiration 24.

On Nov. 2nd, morning temperature was 99.1 5, pulse 68, respiration 26. Evening temperature, 101.1-5, pulse 70, respiration 34. There was also a diminution of the cervical hyperæsthesia and a feeling of a band across the epigastrium. Patient had three involuntary evacuations the same day.

Nov. 3, morning temperature 99.4-5, pulse 72, respiration 26. Evening temperature 102.2 5, pulse 80, respiration 28. There were no cremasteric or abdominal reflexes, but there was still noticeable a slight reflex movement of feet, obtained by tickling the soles. Urine was drawn twice daily until Nov. 4th, when the patient left the hospital.

Nov. 5, Dr. Winslow was summoned to Mr. Dugent's home, and found him perfectly conscious, free from pain, but suffering from nausea and every few minutes regurgitating, without any effort whatever, large quantities of dark vomit.

Patient had not passed water since he left the hospital. Abdomen was tense and about ½ gallon of urine was withdrawn by the catheter. He immediately went into collapse, becoming unconscious, respiration almost ceasing, pulse greatly reduced in strength and frequency, his lips blue, and everything indicated immediate death. From this condition, however, he soon began to rally, and in a half-hour he was conscious, with a good pulse, but with some difficulty in respiration.

About Nov. 10, bed sores appeared on shoulders and buttocks.

After earnest and repeated solicitations on the part of the patient to be operated upon, and after many explanations on the part of the attending surgeon as to the dangers of a surgical procedure and the gravity of its probable result, an operation was decided upon and Sunday, Nov. 12th, was the day appointed. After the patient had been put to sleep with chloroform, Dr. Winslow made an incision from the external occipital protuberance to the first dorsal vertebra. He exposed the spinal column, found the arches of the 4th and 5th vertebræ in fragments, 8 of which were removed. The cord was mashed, dura mater torn, and a free flow of spinal fluid occurred. There was also considerable venous hæmorrhage. No untoward symptom was observed throughout the operation. After patient had been carried to bed, respiration became bad and stopped. Artificial respiration was tried, but its success was only momentary and breathing soon ceased again. Mechanical means were again tried but without avail, and such attempts were ineffectual, as were a few hypodermics of whiskey and nitroglycerin, which were given to retard approaching dissolution. Patient died about one hour after the operation and before he had emerged from the unconsciousness of anæsthesia. It was noticed that the pulse continued about 10 minutes after the cessation of the respiratory movement.

Second case.—On Oct. 11, 1893, while performing on a trapeze (at the Baltimore Cedar Works), John Henry Mapp, a colored youth of 19 years, fell a distance of 10 feet, on his head. He was brought to the hospital about 5 in the evening. There was no mark of violence whatever upon his head, which was slightly extended. There was considerable hyperæsthesia about the neck. Motion was retained to a great extent in the shoulders and arms, impaired in the forearms and lost in the hands. Cry of pain was elicited by pricking the arms with a pin, but no such response could be obtained by similar treatment to the rest of the upper extremities. There was some sensation over the upper part of the throat, extending down to the nipples. Abdominal breathing was apparently increased, probably on account of the absence of thoracic breathing. Power to cough was lost entirely. There was complete paralysis of the lower extremities. Tickling the soles of the feet brought forth no reflex, which, however, might have been accounted for by the thick callus which padded the plantar surfaces. The abdominal and cremasteric reflexes could not be brought out. Urine was drawn and found to contain no albumen or sugar, to be acid in reaction and to have a specific gravity of 1030. Priapism was observed 24 hours after admission to the hospital.

The first question that arose in the minds of the attendants was whether the patient was suffering from shock or from compression of the cord. The latter opinion was the one most generally held, and so on the eighth day after the accident, Dr. Winslow did a laminectomy.

The sixth and seventh vertebræ were found fractured, the cord compressed; the laminæ and spines of the former were removed. It may be said here by way of parenthesis that while the patient was still upon the operating table it was observed by those standing around that he was moving his thorax in respiration, which he had not done since he was injured. This phenomenon lasted only a few minutes and was not noticed later on. Its cause is rather a matter of conjuncture. Perhaps it was due to the local stimulation of the cord or to the release of the compressed cord when the fragments of bone were removed. The wound did nicely but the premature removal of the suture converted what seemed to be primary union into a granulating surface.

The operation did the patient no harm, nor was it, as far as could be seen, of any material benefit. There upon his bed he still lay as before, his thighs and legs as motionless and his bent hands as powerless as before. The robust youth of a few days ago had become without any visible defect of bone or muscle even more helpless than the newly-born. The appetite remained good, mastication and deglutition perfect, but his food and drink had to be put into his mouth by the hands of a nurse. Even his emotions were unable to find their wonted expression, and his repeated attempts at laughter resulted only in a distorted countenance. To this picture of helplessness which our patient presented in the early and middle periods of his sickness was added another, in which he was seen to take no comfort in the company of friends or relatives; when he could no longer talk of past events; when he could no longer ask a reasonable question, nor give a rational reply.

When the mental faculties had gradually died away, they left him indeed an object of pity and commiseration. Hallucinations and loud outcries, first at night and later during the day, were followed by somnolence and low muttering of incoherent thoughts. Indifference to food preceded but shortly its absolute refusal, and it was about this time that the patient would bite to bleeding the ends of his long thin fingers and the lips of his already pinched and shrunken mouth. The purposeless movements of the head quieted down to a comatose calm and the emaciated form with its atrophied muscles and spreading bed sores finally gave up the ghost 58 days after admission to the hospital.

There are a few remarks which may be made with profit. About 4 hours after the accident, temperature was 96. 1-5 and pulse 46. The former varied much throughout patient's sickness, falling in the morning and rising in the evening. The highest point reached was 105.2-5 at the end of the third week; lowest point was 95° twenty-four hours before he died. The greatest fall of temperature was 7.2-5°. During the last 60 hours of life it was below normal, but arose to 102 immediately before death.

Pulse during the first week averaged

58, during the second week 65, third week 73, fourth 74, fifth 86, sixth 76, seventh 86, eighth 106 and ninth 144.

Respiration was 19 upon entrance to hospital and was between 20 and 24 throughout, until near the end it was 32 and just before the close of life it was 48.

There was obstinate constipation for the first four days, and in the seventh week there was a tendency to diarrhœa. Involuntary evacuations first occurred during the second week, and continued throughout his sickness.

Patient was catheterized twice daily for the first five days, after which time urine dribbled continuously. The catheter however was inserted every few days to insure against distention of bladder, but very little urine was drawn. The amount of urine at first was small, at one time 4½ ozs. in 24 hours, while later on the quantity increased; in the second week 70 ozs. were passed in one day and 82 ozs. during another. In the last week it was considerably decreased. Reaction was at first acid, then alkaline. Specific gravity was 1030 and two weeks later 1020.

Under the faradic current the muscles of the entire body responded very well except those of the legs. By applying one pole to the sartorius muscle and the other pole to the iliac region the whole extremity would rise entirely from the bed. This sensitiveness to faradism gradually subsided until finally no reply could be obtained.

After reviewing these two cases it might appear presumptuous on my part to make any recommendation to this Society. However, I think that in cases of vertebral fracture the most opportune time for a laminectomy is immediately after the accident.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD FEB. 2ND, 1894.

The 290th regular meeting was called to order by the President, Dr. J. E. Michael.

Dr. P. C. Williams, in his remarks on the use of "Tarnier Forceps in Occipito-Posterior Positions," said: In my early days nearly all the ruptured perineums I saw were due either to post-occipito positions or to delivery of the shoulders. Two of the most advantageous points about this instrument are the ball joints at the handle and at the traction rods. As you pull, the handles begin to rise and then to rotate. When the head has reached the floor of the pelvis it is advisable to remove the forceps, detach the rods and again apply the blades in their usual position; otherwise you are apt to injure the soft parts. The first time I used Tarnier's forceps was in the delivery of a child with a very large head from a rather small woman. As soon as I began, traction rotation took place and I had an easy delivery.

The larger the head, the more certain is it that rotation will occur during traction. I consider them the ideal forceps for all high positions of the head. They can be used in utero without any trouble.

Dr. Wilmer Brinton read a paper on "Recent Experiences with Axis Traction Forceps."

CASE 1. Louisa Jackson, colored; was admitted to the Maryland Lying-In Hospital June 8th, 1893. She was pregnant

with her first child; age 19 years. She made the statement that the "first day of her last sickness" was October 5th, 1892. Within two weeks after she entered the hospital, in the presence of a class of students, I measured her pelvis, using for this purpose Shultze's pelvimeter and my hand. I found the transverse diameter normal, but that there existed a marked contraction of the antero-posterior diameter of the superior strait, being 3½ inches (Monies). At this time and in the presence of students, I stated that, from the measurements, I was sure the woman would have a difficult labor, but if nature did not do the work, that forceps would deliver her, without the necessity of other operative measures on mother or child. Labor pains began a few minutes past midnight, July 20th, 1893. An examination then made by my assistant found the child presenting vertex, with the occiput to the mother's front and left (occipito-læva anterior). From this time on, the pains continued with more or less severity. At 3.30 P. M., some 15 hours from the beginning of true labor, the membranes ruptured spontaneously. At 5.30 P. M., a hypodermic injection of ¼ gr. of morphia was given. She then slept "off and on" until 8 o'clock, when her pains began again, and were of a severe character. I first saw this woman at midnight, after she had been in labor 24 hours. I found her in a good condition, pulse being about 100°, but she complained of feeling thoroughly exhausted. An examination per vaginum found the cervix about half dilated, the child's head above the superior strait and movable; the heart sounds of the child, which were heard to the mother's left side, indicated that the child was in no immediate danger. Under the existing condition, we determined to postpone operative measures until early next morning. Hydrate of chloral, gr. xv, was now given every 20 minutes, until a drachm was taken, and from 3.30 o'clock in the morning until I saw her at six o'clock she had hot vaginal douches every thirty minutes. When my colleague, Dr. Crouch, and myself examined this patient at this hour, we found no material change from the examination made at midnight, with the exception of the cervix being more dilated and dilatable. The head was still movable, the mother was in quite an exhausted condition and we determined on operative measures in the interest of both mother and child. What should it be? Version or high forceps? With some predilection for version in this class of cases, yet we determined on high forceps. The woman was thoroughly chloroformed and Lusk's modification of Tarnier's forceps were applied. After considerable traction, lasting "off and on" for about 40 minutes, we succeeded in delivering her of a living female child. A tear of the perineum was immediately repaired. A brief history of the case as taken from the hospital record book is as follows: 1st stage of labor 29 hours, 2nd stage 50 minutes, 3rd stage 10 minutes; presentation vertex position O. L. A.; child, female, weighed 6½ pounds, length 18 inches. The child was nursed by its mother, who left hospital August 3rd, 1893, after an uneventful lying-in period.

Case 2. At 2 A. M., January 22nd, 1894, my associate, Dr. J. F. Crouch, was called to see Mrs. T., a native of

Ireland, age 24 years. He found her in labor for the second time. She had had true labor pains for two days before the doctor was called; the membranes had ruptured spontaneously 40 hours before. From an inquiry made at this visit it was ascertained that her first labor must have been a very difficult one. She had been under the care of a midwife for nearly two days, when finally a doc tor was sent for, and after great exertion upon his part she was delivered of her child, which only lived a few minutes. An interval of two years elapsed, when she conceived again, and as stated, after having been in labor for nearly two days, Dr. Crouch was then sent for.

He found the child presenting vertex, head high up and movable, fœtal heart heard distinctly to the mother's left. The "os" was found dilated to the "size of a half-dollar." The pains continued all day Monday without pro gress. I first saw this woman at 5 o'clock in the afternoon, some 14 hours after Dr. Crouch first saw her, and nearly three days from the time she first went into labor. I found the patient in an exhausted condition, pulse 128 and bad. She was extremely restless, rolling from one side of the bed to the other. A vaginal examination found the parts hot and dry, the cervix dilated to the size of a silver dollar, but rigid and œdematous. the presenting part, in my opinion, being a brow; while examining, I pushed up the presenting part and in the light of subsequent events, I believe, I caused enough flexion to transpose what was undoubtedly a partial brow into a vertex presentation. While thus engaged in pushing up the presenting part, I had no trouble in making out with my fingers a marked deformity; the promontory of the sacrum projected to such an extent that the antero-post diameter of the superior strait was estimated to be less than 3½ inches. We revisited our patient at 8 o'clock P. M., found no progress, pulse more rapid, exhaustion very decided, the cervix more œdematous, the head still movable above the brim of the pelvis. We decided to delay no longer. Chloroform was given to full anæsthesia. *Neal's Axis Traction Forceps* were applied and after considerable traction a medium-sized male child was delivered. The child was asphyxiated, but was soon restored to animation by the usual methods. The *placenta* was delivered by Crede method 15 minutes later. The uterus contracted and retracted well, but considerable blood was lost; but the hæmorrhage was soon under control by kneading the uterus, hand in uterus, and uterine injections of hot water. The patient has had no trouble during her lying-in period, and now on her 11th day is going about her room. The child still shows evidence of pressure about the cranium, but is prospering and will do well. As we never saw the woman until we were called to see her after being in labor two days, we did not have the opportunity of measuring her pelvis. We hope to do this accurately within a fortnight, and we shall report the results later. In this case the deformity was of such character as to lead one to indulge in thoughts of the fashionable "fad"—the now popular operation symphysiotomy. But even with this operation, could our results have been better?

The papers were discussed by the following members:

Dr. L. E. Neale: The instrument which bears my name is not original with me, but is a combination of the

good points of many others. The blades are from Wallace's instrument and were selected because of their peculiar basket-shaped curve, which enables them to hold fast. The shanks are wide in order to conceal the traction rods, the attachment of which is very simple and rapid. The compression screw is placed at the end of the handle, out of the way, and can be easily removed. It only has one ball joint, but rotates completely. I agree with Dr. Williams, however, that it is best not to allow the instrument to remain in rotated position. The principle of axis traction has come to stay and we should have for general use an instrument admitting of axis traction application if desired. The four cardinal points obtained by axis traction, as laid down by Tarnier, should be at hand in one instrument.

Cases which originally present occipito-posterior positions will usually rotate anteriorly if let alone. Only about 4 per cent. of such cases remain posterior, hence they do not by their position alone indicate interference. In many of these cases the uterus may have clamped over the back of the child in such a way as to hold it, no matter how the head moves. In a large majority of the 4 per cent. of cases, retention is due to lack of flexion. Now when we produce flexion, we have made the head smaller, so I differ with Dr. Williams' conclusions about a large head. We can try to get rotation by raising the brow or by use of vectis, &c., before resorting to forceps. Some cases will fail to rotate no matter what method or what forceps you use and will have to be removed with occiput remaining posterior.

Dr. J. Edwin Michael: The present forceps are the outgrowth of a principle the value of which has long been recognized.

The introduction of Tarnier's forceps was a great step in obstetrics. By them you can make traction and not interfere with rotation and you can apply your force in a direction in which it is needed. Your traction is in a line corresponding with the axis of the superior strait and in the direction which the head must follow. While the forceps do not facilitate rotation they do not hinder it. I believe that in most cases where rotation occurs with the instruments it would have occurred anyway and we did not produce it. I have tried all the devices in those cases which persist in posterior position and yet they have failed to rotate. When I deliver without rotation I always expect and usually get lacerations of perineum.

Dr. Craighill: Dr. Michael has called to mind a case which illustrates well the advantages of axis traction forceps. The patient had a contracted pelvis and the position was occipito posterior. Both Hodges' and Simpson's forceps were tried by Dr. Mitchell and myself, but both failed. We tried nearly all devices and were considering craniotomy when we concluded to try first Tarnier's forceps. Dr. Michael was sent for, applied the forceps and delivered the child promptly and easily with one hand.

Dr. W. S. Gardner: The consideration of the mechanism of axis traction forceps includes the following points:

1st. The pelvic curve of the instrument should be made to correspond as nearly as possible with the curve of the unyielding portion of the pelvic canal.

2nd. The cephalic curve should be so constructed as to give a firm grasp of the

head of the child without too much compression.

3rd. The traction rod and handle should be so placed that traction will be made as nearly as possible in the direction of the pelvic canal.

4th. The instrument should be made of material that can be sterilized by heat without injury.

Dr. Gardner then proceeded to explain the difficulty of determining the axis of the inferior strait and the fallacy of some of the usual statements made considering the relation of the head to the pelvic outlet, and concluded that in so far as pelvic curves are concerned we can never do more than approximate the truth. As we cannot have a new instrument for each patient, the best we can do is to use that instrument which is most nearly correct for the largest number.

Dr. W. E. Moseley: I wish to say a few words in defense of an old friend. It has been said here that the Hodge or Simpson forceps make an irreducable occipito-posterior position. I do not think that is correct, for I have seen rotation occur with Hodges forceps on.

Dr. P. C. Williams: Obstetrical mathematics would be very good if we could make the parts we are dealing with. In the majority of occipito-posterior cases rotation forward will occur, but they create much suffering for the patient, and I believe it is our duty to save as much pain as we can without danger to mother or child. So when I diagnose O. P. position, I think it best to terminate it as soon as I can safely. I am sure forceps do aid directly and forcibly in producing rotation.

H. O. Reik, M. D., Sec'y.

525 N. Howard Street.

BALTIMORE MEDICAL ASSOCIATION.

MEETING HELD DEC. 18, 1893.

Dr. J. I. Pennington, President, in the chair.

Dr. Eugene L. Crutchfield read a paper entitled, "Breathing Exercises a Curative Measure for Consumption, with a New Theory Advanced as to the Ætiology of that Disease."

In the discussion, Dr. David Streett said he was surprised that no reference was made in Dr. Mays' paper to savages, as they are especially prone to consumption. Breathing to be complete should be both abdominal and costal. Persons in elevated regions do not have consumption and the bacillus tuberculosis does not thrive because of the diminished pressure on the pulmonary capillaries. The disease does not advance beyond the incipient stage in Denver, Col., which is one mile above the water in Baltimore harbor. Epistaxis and dyspnœa occur in strangers, but are absent in residents in this locality. He noticed that on Pikes Peak epistaxis and dyspnœa were marked and that his pulse became frequent, over 100, when sitting in a car, and that several persons fainted. There was pain in the frontal sinuses because the superficial capillaries were congested. He thinks that immunity from consumption exists in high altitudes because the lungs are better nourished on account of the dilatation of the capillaries.

Dr. J. W. Chambers: Much interested in the subject. We have two conditions to contend with, viz., the bacillus and its growth. The second is controlled by exercise. An organ is healthy only because it is physiologically used. It is

unhealthy when physiologically abused (excessively used). We should remove children from tuberculous parents but sentiment prohibits.

Athletes and prize-fighters have consumption because of abuse of constitution. Exercise increases circulation and resistance to tubercle. Most persons habitually use but a part of the lung capacity. Training as suggested by Dr. Crutchfield utilizes all this capacity. If consumption is in its last stages, it is dangerous to go to a high altitude, because one cannot get sufficient air and must in his efforts to do so overwork what good lung-tissue he may have left. He trains his own children to breathe properly, and practice counting as much as possible. They can gradually acquire the ability to count more while holding the breath than at first. Breathlessness on exertion has been largely removed by these habits in his own person.

Dr. Streett: One would suppose that laborers would be less susceptible to consumption than others because they breathe deeply. Emphysematous lung rarely becomes tuberculous. It contains much air, the septa are ruptured and the capillaries destroyed with consequent dyspnœa.

Dr. J. I. Pennington: Dress in newly-born infants is too tight about the abdomen and is kept so for months. Patients should be instructed to make their clothes hang from the shoulders with no constriction about the abdomen. Laborers on farms who are obliged to exercise the arms and keep the chest erect, rarely have consumption. Clerks with arms but slightly used often have that disease; catarrh of mucous membranes predisposes to consumption.

Dr. E. M. Read: The paper is one of great importance, especially concerning the clothing of infants. Pleuritic adhesions predispose to consumption. When there is costal breathing, it is shown by emphysema at the apex. Advocates outdoor life for his patients to insure pulmonary aëration. No single agent has yet been found to destroy the germ of the disease.

Dr. Crutchfield: The lungs should be free to expand in every direction, but abdominal breathing is the most important. Deep respiration causes increased circulation in the lungs, in high altitudes. Athletes and prize-fighters do not, as a rule, breathe correctly. This mode of treatment is beneficial only in the early, and not in the later, stages of consumption. Laborers do not always breathe correctly. Pleuritis and pneumonia are predisposing causes which this treatment will combat. (During the discussion of this paper, notes were taken by the Cor. Sec., Dr. E. D. Ellis.)

Dr. Streett inquired about the type of influenza prevailing in the city at present. In his experience it is milder than in former years. Bronchitis, however, is more liable to follow.

Dr. E. Dorsey Ellis thinks that no special type prevails. It differs but little from numbers of cases occurring at this time of the year to which we give no name at all.

Dr. John D. Blake hopes that some one will prepare a paper on the subject, Is it contagious? If so, what is the period of incubation? We often see several members of a family ill with it at the same time. In surgical practice he has noticed that those having recently undergone surgical operations are more liable to it.

EUGENE L. CRUTCHFIELD, M. D.,
Rec. and Rep. Sec'y.

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BALTIMORE, MARCH 10, 1894.

Editorial.

THE INTERNATIONAL CHOLERA CONFERENCE.

The International Cholera Conference which will shortly commence in Paris promises to be an affair of more than ordinary interest and importance. Its work may, therefore, be looked forward to as a valuable contribution to the study of cholera, from the standpoint of prevention and extinction. The Conference will chiefly occupy itself with tracking chlorea to its seats of origin in Asia and with measures to be taken relating to the defense of Europe against this disease.

Investigation has very clearly shown that the prime focus of cholera is India, and that it owes its spread to the Indian fairs and Meccan pilgrimages. That cholera has its origin in filth, that it is a poison or contagium conveyed from man to man, chiefly by swallowing water contaminated with the poison, has been too clearly proven to be disputed. Cleanliness is its most powerful enemy, but cleanliness is powerless in the absence of those preventive measures which can cope with the cholera germ.

Sanitarians and quarantine authorities have tried to contend with the ravages of cholera through the agency of disinfection and quarantine regulations, but men of larger observation have argued that the only successful method which can be employed to destroy the disease is to stamp it out in its original home in India. It is claimed that the primary object should aim to secure such measures as will suppress the disease at the Hardwâr and other Indian fairs, and at the Meccan pilgrimage.

In India, cholera exists on every side. The habits, customs and practices of the Hindus foster the disease and spread the germs over wide areas of country.

The religious customs of these people are largely responsible for the widespread influence of the disease and until these customs are regulated by better sanitary regulations little can be done to exterminate the disease in its favored home.

On various occasions these people congregate in immense numbers in various places where their religious festivals are held. One of the most notable of these festivals is known as the Hardwâr Fair, which is held annually and is regarded by Hindus as an occasion of peculiar sanctity. The town of Hardwâr contains a population of less than 30,000 people. It is located on the Ganges just at that spot where it escapes, cool and clear, from its upland home. It is a favored locality for the assembling of the religious, where they congregate in immense numbers, varying from 500,000 to 1,000,000 pil-

grims. These people bathe freely in the waters of the holy stream, which is one of the objects of these fairs and festivals, and at the same time drink of its holy waters.

Throughout India these religious customs prevail, and through the habits and practices of the superstitious cholera claims its victims annually by the thousands. After these festivals are over the pilgrim returns to his home and carries infection with him.

It is no surprise that cholera continues as a scourge of the human family in India, and that its germs are carried to far distant countries. The object of the Conference in Paris will be to determine upon such methods as will eradicate the disease in India and arrest its spread to other nations. We may regard its conclusions with interest and with the hope that practical results will follow. If the civilized nations of the world agree to unite upon practical methods for the suppression of cholera, a decisive victory over the disease will be won.

A MEDICAL DESPOT.

Professor Zakhärin, of Moscow, who has succeeded the late Professor Botkin as physician to the Czar of Russia, presents a very interesting personality, and not unlike his noble patient, is somewhat of a despot.

Some of his peculiarities and eccentricities have been described by a correspondent to the *Brit. Med. Jour.* (Feb. 17th, 1894). They are sufficiently novel to become interesting.

Prof. Zakhärin is 65 years of age, and has been professor of clinical medicine in the Imperial University of Moscow for the last 35 years. He was the first physician in Russia to introduce exact clinical examination and treatment. He has accumulated a fortune of $2,500,000 by the practice of his profession, thus indicating an enormous business.

His success has engendered a manner which, whilst possible in Russia, would hardly lead to success in any other country. He shows his power in a very peculiar way. "Special arrangements must be made in every house in which he sets his foot; all dogs must be kept out of the way; all clocks must be stopped; all doors must be thrown wide open. The professor, on entering, begins a process of gradual undressing, leaving his furs in the hall, his overcoat in the next room, his goloshes in the third, etc. He insists on perfect silence on the part of the afflicted relatives, except in reply to his question, when their speech must be literally 'yea' and 'nay'."

Naturally the professor is greatly feared, and yet his abilities are said to be of such a high order that his services are eagerly sought by the nobility of Russia. Some eight years ago a public agitation was gotten up in opposition to him in which many hundreds of doctors took part, and the press took up the matter.

The then General-Governor of Moscow sent for the editor of the medical journal in which addresses were printed, and told him if he printed a word more about Zakhärin he would have to leave Moscow in 24 hours. This illustrates his remarkable popularity and power with the powers that be. Prof. Zakhärin is very thorough in his methods of treatment. He keeps his patients often two or three hours under examination, and

he never sees a patient without a doctor and he never himself prescribes. He is an individualist—that is, he employs no cut-and-dried prescriptions, but treats every case on its merits. His success in relieving chronic cases has been remarkable.

His present position as physician to the Czar was bestowed on him in recognition of his success in treating the Czar in an illness in which he had been called in through the persuasion of the Czarina.

Such a medical character is not only interesting, but is instructive. Success has resulted in Professor Zakhärin's case from eminent merit and professional worth. Perhaps he has a right to be a medical despot in such a despotic country as Russia.

Medical Progress.

SURGERY OF THE TRIFACIAL NERVE.

H. Reineking, M. D. (*International Medical Magazine*, February, 1894), after briefly reviewing the literature of this subject, and considering some of the important modifications as made by Carnochen, Thiersch, Heuter, Koenig, Leucke, and Mussbaum, refers more especially to the removal of the Gasserian ganglion and to intercranial neurectomy as practised in the last three years by Horsley, Andrews, Rose, Hartley, and others.

He then reports a case, a summary of which is as follows:

J. B. M., a farmer, sixty-three years of age, gives a history of pain in the right supra-orbital region for ten years, and in the right infra-orbital and right occipital regions for five or six years. Within the last two or three years the pain has extended to the upper molar teeth. It generally starts in the frontal region and is never first in the occipital. It is accompanied by twitching of the muscles of the parts affected. The case is one of very severe chronic intractable neuralgia of some of the branches of the ophthalmic and superior maxillary divisions of the trifacial nerve, accompanied by less severe but equally obstinate neuralgia in the region of the great occipital nerve.

Neurectomy of the frontal and infra-orbital nerves was decided upon, and the following operation was made: the supra-orbital nerve was exposed at its point of emergence from the supra-orbital foramen, liberated by chiselling away a small portion of the ridge, and separated as far back in the orbit as possible. By traction, twisting, and a little dissection of the nerves, nearly all of the orbital portion and its branches were removed. The infra-orbital was exposed by removal of the roof of the infra-orbital canal, and grasped and twisted off in the same manner as before. A small opening into the antrum of Highmore was accidentally made, and was drained for three or four days. The wound healed by first intention, and all pain disappeared in about three days.

The points in the treatment on which the writer would lay especial stress are: 1. Thorough following up, extracting, and dissecting out of the peripheral, muscular, and cutaneous branches; 2. Slow torsion, and gentle stretching of the central stump until it gives away.

Dr. A. G. Hoen, of Waverly, is quite ill with Bright's disease.

RESECTION OF THE RECTUM AFTER THE REMOVAL OF MALIGNANT GROWTHS.

Marcy (*Matthew's Medical Quarterly*, vol. i, No.1) holds that as soon as the diagnosis of rectal cancer is established, while the invasion of the parts is yet limited and local, inguinal colotomy is to be performed. The operation must be performed in two different stages—that is, a loop of the descending colon is to be fixed in the abdominal wound, and there allowed to remain for several days, until the peritoneum is shut off by adhesive inflammation, before the intestine is opened. Performed in this way colotomy is an operation of comparatively little danger. The lower segment of the bowel is thus put at rest, emptied of its contents, and easily disinfected.

This having been accomplished, an incision is made in the median line posteriorly to a point just below the end of the coccyx. The coccyx and a sufficient portion of the sacrum are removed to permit ready access to the bowel. The intestine is first freed posteriorly for about two-thirds its circumference, and the peritioneal cavity is opened sufficiently to allow of easy manipulation of the intestine. The rectum is now divided transversely at the lower border of the disease; the upper segment is split longitudinally along the posterior wall, thus not only exposing the diseased structures,but facilitating the dissection of the intestine from its anterior attachment, which, in the male, is the more difficult because of the intimate relationship of the parts to the prostate and the base of the bladder. When this dissection is effected the bowel is divided transversely above that portion which has been invaded by the disease. A further division of the meso rectum is now made sufficient to loosen the attachment of the intestine, so that its upper portion may be readily brought down to the line of its inferior division. This having been accomplished, the continuity of the gut is restored by suturing, or, in the case reported by Marcy, the Murphy button, reinforced with a line of sutures. The peritoneal opening is then sewed, and the wound, according to Marcy, is closed without drainage. The discharge of the button is insured by a silk suture secured to it and brought out through the anus. The advantages obtained by the operation are the radical removal of the disease, which, when accomplished at a sufficiently early period, gives expectation of further exemption from it. The sphincter and the anal structures are retained uninjured in character and function. The external tissues are normally approximated, and the lesion of the sacrum gives very little, if any, permanent disability.

Subsequent operation for the restoration of the intestine divided in the colotomy, and its replacement in the abdominal cavity, restores the bowel in its continuity and function.

Medical Items.

Health Commissioner McShane, of Baltimore, has gone to New York and Boston to inspect the methods of garbage disposal in use there.

The daily press announces that a vessel has arrived at New York from London with yellow fever on board. One case died and several are ill with it.

Dr. Guido Baccelli and Francesco Durante are the editors of a new Italian medical journal published in Rome and called "Il Policlinico." It appears every two weeks.

Professor H. J. Johnston-Tavis, of Naples, has kindly offered to aid and advise American visitors to the Eleventh International Medical Congress during their stay in that city.

Dr. Martin Luther, a prominent physician of Reading, Pa., a graduate of Jefferson Medical College in 1848, and a lineal descendent of the great German reformer, died recently in his 68th year.

An exchange is authority for the statement that Dr. Abraham Jacobi, of New York, was offered and refused the chair of pediatrics in the University of Berlin, as successor of Professor Henoch.

The bills introduced in the General Assembly of Virginia, to admit women to the University, and providing for the appointment of female physicians for the insane asylums, failed to pass.

The Pennsylvania Legislature is very stingy in its grants to the State Board of Health, but makes it up in appropriations to medical schools in Philadelphia, among three of which it has distributed this year the respectable sum of $330,000.—*Med. Rec.*

The Anne Arundel Medical Society has elected the officers: President, S. H. Anderson; Vice President, Geo. Wells; Recording Secretary, V. R. Davidson; Corresponding Secretary, C. B. Henkel; Treasurer, F. H. Thompson; Executive Committee, H. B. Gantt, J. W. Dubois, S. D. Kennedy; Finance committee, C. B. Henkel, W. O. Clayton, Geo. Hammond.

A circular of general information has been issued by the Secretary-General of the Eleventh International Medical Congress, to be held at Rome from March 29th to April 5th, copies of which, together with the traveling documents, can be obtained from the Chairman of the American National Committee, Dr. A. Jacobi, 110 West Thirty-fourth Street, New York.

The building committee of the medical department of the Maryland University, appointed by the faculty to consider plans for the reconstruction of the laboratory which was destroyed by the fire of December 2d last, met and decided to rebuild the laboratory on the old lines as near as possible. It is intended that the building shall be erected and ready for occupancy by the coming session.

At the meeting of the Executive Committee of the Johns Hopkins Hospital, held last Tuesday, Dr. Delano Ames and Dr. F. H. Fincke were reappointed assistants for one year in the general medical dispensary. Dr. John Hewetson was appointed as a delegate from the hospital to the International Medical Congress, which meets in Rome, Italy, during the spring. He will read a paper on malaria. After the adjournment of the Congress Dr. Hewetson will take up a course of study in the leading hospitals of Europe. He will be absent two years.

The municipal authorities of Portsmouth, O., have enacted an ordinance

requiring all traveling physicians engaged in ephemeral practice to take out a license in order to do business, paying for the same at the rate of from twenty-five to one hundred dollars per day. The enactment of such ordinances in all the cities and towns of Ohio and Indiana would do very much toward ridding the States of these cormorants, who flit from one town to another as birds of prey and evil omen, who fleece the ignorant and unwary.—*Cinn. Lancet-Clinic.*

A Bill for Food Inspection has passed the Maryland Legislature and is now to be brought before the City Council of Baltimore. This bill advocates special attention to the inspection of milk, which is to be examined once or twice daily at each railroad station and depot on its arrival, and if it does not come up to the standard it will be confiscated and poured out. The dairies in and about the city will also receive attention. There will probably be appointed five inspectors and they will also look into the condition of meats, fish and fruit in the markets and at the wharves.

A number of months ago we took occasion to call attention to the noble work of Duke Karl Theodor of Bavaria. It transpires that another member of the same house, Prince Louis Ferdinand, has likewise engaged in the practice of medicine. The Prince is the cousin of Duke Karl Theodor, nephew of the Prince Regent of Bavaria, husband of the Infanta Maria de la Paz of Spain, and is twenty three years old. He has recently published a monograph detailing the results of a study of the etiology and pathology of pleurisy, based upon clinical, bacteriologic, and therapeutic observations in twenty-three cases.—*Med. News.*

The daily papers announce that a number of colored physicians and others held a meeting at St. John's A. M. E. Church, Orchard Street, last Monday night, when it was determined to establish a hospital for colored people. The name chosen was "The Baltimore Colored Hospital," indicating at once the character of the institution, the need of which has long been recognized by the colored people generally, as well as physicians, white and colored. The latter intimate that they expect the institution to be the germ out of which will also grow a Baltimore colored medical college. The colored physicians of the city inaugurated the movement for founding the hospital at a meeting held at the residence of Dr. W. T. Carr, Jr., last week. The meeting resulted in the decision to have the hospital, and in the appointing of the medical staff, as follows: Dr. R. M. Hall, visiting physician and dean of the hospital; Dr. Carr, diseases of children; Dr. Thompson, of St. Paul Street, obstetrics; Dr. J. Morris Carghill, of Biddle Street, diseases of women; Drs. Fowler and Harris, surgery; Dr. Credit, of No. 420 Pine Street, genital and urinary diseases; Dr. Dyer, of South Baltimore, physician in charge. At Monday night's meeting a resolution was passed requesting all colored clergymen of the city to send three representative men from each church to a meeting to be held at a later date for the purpose of putting the movement in proper shape. The hospital, it is thought, will be a success. It will, probably, be started in a rented house, and grow gradually.

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Original Articles.

DETENTION WARDS FOR CASES OF SUSPECTED INSANITY.

BY GEORGE J. PRESTON, M. D.,

OF BALTIMORE.

In a paper presented to the Medical and Chirurgical Faculty of Maryland at the last semi-annual meeting, brief reference was made to the need in our city of a detention ward for the reception of cases of suspected insanity. At present all such cases falling into the hands of the police are sent to the station houses and treated as criminals. It is of course highly improper to treat as a criminal a person concerning whom there is a reasonable doubt as to the mental condition and consequently as to the responsibility. Humanity demands that we give this unfortunate person the benefit of the doubt and inquire into his mental condition before fastening upon him the stigma of criminality. These remarks refer to such persons as are arrested for trivial offenses, and who are suspected by the police justices of mental aberration. That the station house is no fit place to confine either the violently or mildly insane is too obvious to admit of discussion. Cases of acute mania require careful handling and should be under constant medical supervision and their wants attended to by assistants who have had some training and experience in such cases. In regard to the mildly insane, including so-called "cranks," the station house is far from being a suitable place for their detention. Arrested, usually for some trivial

offense, they are necessarily greatly excited by the surroundings of the station house. In some instances the unfortunate individual construes his unimportant dereliction into a great crime, seeing that he is arrested and perhaps lodged in a cell. Again, in another class, the insane vanity is flattered by the importance of an arrest and imprisonment. In either case the effect produced is positively bad. Another objection to this mode of dealing with this class of cases is that it is impossible to make a satisfactory examination, and consequently a proper disposition of them. The general surroundings, the companionship, or at the least the propinquity, of criminals, alcoholics and tramps, the powerful stimulation of the emotions, shame, anger, fear, the noise and bustle, the publicity—these and like conditions render it utterly impossible to examine the mental state of the suspected individual with the care that the dignity and responsibility of the subject demands. Any one who has ever been obliged to make such an examination under such conditions will appreciate what has been said regarding it.

The statements made above are too obvious to require any elaboration, and the mere mention of them suffices to emphasize the crying need of some more suitable place for the temporary reception of persons suspected of mental alienation. In a very interesting and suggestive paper read before the last meeting of the American Neurological Association, Dr. M. D. Field, of New York, gave a summary of the work done in the detention ward of Bellevue Hospital.

The reception pavilion is a plain, inexpensive structure with 16 rooms, 8 on each side, with a corridor to each side, the rooms being lighted and ventilated from above. One side is set apart for males, the other for females, and proper attendants are provided. Since its opening in 1879 about 25,000 suspects have been received. In 1891 there were admitted 1.138 males and 866 females. Of this number, 780 males and 694 females were transferred to asylums. The police justices are allowed to commit for examination regarding sanity such persons as manifest evidences of insanity, in these classes:

1. Those persons who are arrested for petty offences, the nature and manner of the occurrence indicating an unbalanced mind.

2. Those who interrupt public meetings or divine service, who preach or orate in public places, their conduct appearing to be irrational.

3. Persons making complaint before police justices, at police stations, in other courts, to the district attorney, or other public officials, of wrongs and persecutions, or claims that appear to be imaginary.

4. Where complaint is made by citizens of persons who annoy them upon pretence that seems irrational.

5. Persons who may be found by the police wandering about the streets in an aimless or purposeless manner, or acting in a strange manner, or who are unable to give a rational account of themselves.

6. Those who have attempted suicide.

7. Those who are brought before a public magistrate, where the charge of testimony would warrant the suggestion that the individual might be insane and irresponsible.

The commitment to the detention ward

is generally for 5 days, and persons found "not insane" are returned to court.

A few of our large cities have such wards, or what takes the place of them. In Boston, for example, "suspects" are sent directly to one of the asylums within the city without commitment until their cases are inquired into. In Baltimore there is no asylum near enough to be utilized in this manner, and as the general hospitals cannot take such cases, the station houses are perforce compelled to receive all the suspects and detain them until they are examined and disposed of.

During the past year 63 persons were arrested and detained at the station houses on the charge of insanity. Of these, 26 were females and 37 males. In looking over the last report of the Police Commissioners it will be seen that there were a large number of arrests made for causes similiar to those given above: indecent exposure, disturbing public meetings, complaints of imaginary wrongs, aimless wandering upon the streets without being able to give a rational account of themselves, and the like. Quite a considerable number of persons are detained at the general hospitals at great inconvenience to these institutions, until they can be committed to asylum. All that would be required for this city would be a small building attached to one of our hospitals, with 6 or 8 rooms, a larger room for examinations, and a room for nurses. Attached to one of the hospitals the expense of conducting such a ward would not be great. In this way a careful study of all suspected cases and a proper disposition of them to the various asylums or reformatories could be made. This method of dealing with this class of persons would not only further the cause of humanity, but in the long run the city would be the gainer financially. The expense of arrests and often of court trials would be avoided.

An excellent feature of the New York law might be added—this is the appointment of two examiners in lunacy, whose duty it is to examine all suspected cases, to make out the commitments and to do the court work in regard to them. This latter is an important point in a large city, and involves a good deal of labor. It is not quite fair to summon members of hospital staffs, either resident or visiting, and require them to testify in such cases; apart from the time consumed, very nice questions are often involved and sometimes great responsibility incurred. The city should designate certain persons to do this work and should remunerate them for it. My experience, both personal and from the statements of others, is that a very considerable amount of time is consumed by our physicians in this work and they are not, as a rule, paid for it.

While our city is making so many and such important municipal improvements, it is our duty as physicians to see that all matters pertaining to the public health and well-being should receive the attention due them, and there is no more crying need than the improvement in the care of our insane.

Physicians of India are reported to have addressed a communication to the International Medical Congress to meet in Rome, asking for the establishment of a medical journal in the Latin language, for the preservation to all eternity of important medical writings in abstract.

REPORT OF A CASE OF TWO SEPARATE AND DISTINCT UTERI, CENTRALLY SITUATED AND NOT CONNECTED.*

BY HANNAH T. CROASDALE, M. D.

The patient, aged sixty-three years, mother of three children, was admitted to the Woman's Hospital for treatment for an abdominal tumor.

Twenty years before, she noticed enlargement of the abdomen, and in five years it reached, she thought, its present dimensions. No discomfort was felt (except from the size) until recently, when she experienced pain and pressure symptoms, and the bladder and rectum became very irritable.

The menopause occurred at fifty, and at that time the woman was confined to bed for several weeks, but there was no especial reason given for this, or she forgot just why she was in bed for that length of time.

Her condition on admission was not very good, although no definite trouble could be found except a systolic heart-murmur. Lungs and kidneys were in good condition.

Pelvic examination externally showed a regular enlargement of the abdomen, and there was percussion-dulness from symphysis pubis to umbilicus and almost from crest to crest of the ilia, with a small area of tympany on the left side. The measurements, as noted, are as follows:

From umbilicus to ensiform cartilage, 8½ inches.

From umbilicus to pubic symphysis, 12 inches.

From umbilicus to right anterior superior spinous process of the ilium, 10½ inches.

From umbilicus to left anterior superior spinous process of the ilium, 10½ inches.

On making digital examination *per vaginam* the cervix uteri seemed small, apparently having undergone senile atrophy, and it was pushed backward and high in the pelvis, the whole uterus being pushed backward. I thought the fundus looked forward, but the uterine sound did not pass readily, hence its use was not persisted in.

What seemed to be a fluctuating tumor was appreciated *per vaginam* to the right of this uterus and above the brim of the pelvis, and a small, tender mass was felt in the right parametrium. The patient complained of pain and tenderness when touched, especially on the right side.

Diagnosis: Fibro-cystic tumor of, probably, the uterus.

After the usual preparation the patient was etherized and the abdominal cavity opened. On opening the peritoneal cavity the omentum was found to be greatly thickened and congested and extensively attached to the tumor beneath it and to the pelvic walls. It was necessary to ligate and cut in many places, and upon pushing the omentum aside the tumor looked pale and felt and looked like a fluctuating mass. A trocar and canula being used, I was surprised that no fluid flowed through the canula.

The incision was now extended in the abdominal wall upward sufficiently to admit of the withdrawal of the mass entire.

A small nodular mass attached to the lower part of the tumor, having the

*Read before the Philadelphia County Medical Society, January 24, 1894.

shape and size of the uterus and being furnished with what seemed to be the uterine appendages, was drawn out of the lower end of the wound and was found to be attached by a small cord-like pedicle to the pelvic brim, a little below the crest of the left ilium.

Another body, to all appearances a uterus with its appendages, was found in the pelvic cavity and fixed by the usual attachments, but had been crowded into Douglas' pouch.

The slender pedicle, not larger than a pencil, which tethered the smaller mass to the pelvic wall, was ligated and cut.

The tumor being now free from its attachments, which were omental entirely, was lifted from its bed. This growth must have derived most, if not all, of its nourishment from the establishment of the circulation through the omentum, for it had almost severed its attachment from other structures, and the omental vessels were enormously enlarged.

The abdominal cavity was cleansed and the opening closed with silkworm sutures, the dressings applied, and the patient was put to bed. Reaction was prompt and good. The temperature for the first four days ranged from 99° F. to 104.5°F. It then rose, and on the sixth day reached 102.6°F., and on the ninth day 105.4°F., when she died of sepsis.

The autopsy showed purulent infiltration at various points in the pelvic cavity. There was also found at autopsy a uterus and appendages, in a healthy condition and in the proper position.

Sections from this little body, which hung from the large tumor, were sent to two pathologists. One reported the specimen as being that of the structure of a fibro-myoma. The other pronounced it uterine tissue, and some structure resembling the endometrium.

If this is a separate and distinct uterus, and I think it is, it is an unusual case, a unique case.

We know that bodies which are not properly situated are not well organized, and take on disease very readily. This second uterus had developed from its *cervix* a fibro-myoma. As it grew too large for the pelvic cavity and rose above the brim, the little organ was inverted and so hung suspended from it.

It measures from the internal os to the fundus one and one-quarter inches. The length and size of the cervical portion is exaggerated, evidently from the tension upon it, but as it was cut open in the fresh state it showed quite distinctly the arbor vitæ arrangement of the mucous membrane lining the canal, and the lips and cervical canal were quite natural in appearance. The os internum on the left side admits the passage of a small probe, which passes a little distance along the Fallopian tube. On the opposite side the opening would not admit of the passage of the probe. There are two small ovaries which, on being cut open, showed on macroscopic inspection ovarian tissue.

No microscopic examination of this tissue has been made. In the cervical canal, just below the internal os, is a small calcareous deposit.

The didelphic uterus we have seen, and these cases are actually two uteri, separated as far as the cervix and including it, and not two bodies more or less divergent, as in the case of the uterus bicornis. Olivier's specimen of a uterus

didelphys, and divided vagina with a distinct cervix uteri looking each into its own vagina, was taken from a woman who had been pregnant five times. Each segment presented the appearance of a complete uterus, seeming to be two unicorn uteri equally developed and apposed without fusion.

It used to be thought that this malformation occurred only in non-viable embryos with deformities of other organs. It has been seen with ectropion of the bladder, with imperforate anus, and other malformations. But an entire organ, far removed from one in the usual location, I have not seen mentioned.

SOME OF THE DISADVANTAGES OF SOLUTIONS OF BICHLORIDE OF MERCURY IN SURGICAL PRACTICE.

BY THOMAS A. ASHBY, M. D.,

Fellow of American Gynæcological Society; Professor of Diseases of Women, Baltimore Medical College; Etc.

The bichloride of mercury has been recognized by some authorities as superior to all other therapeutic agents in its germicide power.

A solution of 1 to 1000 will prevent the germination of seeds and the communicability of the vaccine virus. It will destroy the life of plants, leeches and fish immersed in it (*National Dispensatory*, 1894, p. 821). It is ranked as first among all known agents as a disinfectant (Marcy). Its value as a disinfectant has led to its almost universal use in surgical practice where disinfection is employed.

Its use has become so general for washing hands, instruments, sponges and for cleaning tissues and wounded surfaces, that much injudicious and indiscriminate work is done with its different solutions.

Recognizing its great value for many purposes, I am satisfied from observation and reading that greater caution should be exercised in its employment if we desire to secure its full advantages and eliminate its harmful effects.

Many individuals possess idiosyncrasies, which render the constant use of the drug more or less hazardous. The literature of the profession contains numerous cases where grave and fatal accidents have occurred from its use as a disinfectant in surgery and obstetrics.

A solution applied to the unbroken skin has been known to produce poisoning. Nurses and surgeons have been mercurialized by simply washing their hands in a solution of 1 to 1000. Diuresis, gastro-intestinal irritation, nausea, vomiting, and death by convulsions or exhaustion, have been witnessed as a result of absorption from weak solutions of the agent.

Albuminuria is not an infrequent complication.

Fränkel has collected 14 cases of death from its use as a disinfectant; Peabody collected 22 cases of death from its use in obstetrical practice. Similar observations have been made by other observers.

Sufficient has been said to show that the drug should be used with caution, and to explain symptoms observed after operations referred to anæsthesia, shock, hæmorrhage and damaged kidneys which might more properly be traced to the use of the bi-chloride solutions.

Its value as a disinfectant is limited.

Indications for its use may be summed up as follows:

It is of special service in cleaning the hands of the surgeon prior to and during an operation; it is of equal service in cleaning the skin which surrounds the field of an operative wound; it is one of our best solutions for cleaning the vagina and uterus preparatory to plastic work on these organs, and in removing the debris which has been infected.

I employ it extensively in gynæcological surgery within the vagina; never for gynæcological work within the abdomen. It should be used before an incision is made and rarely, except in weak solutions, after the incision.

On an unbroken mucous surface it is harmless if not left in contact with the surface long enough to occasion an absorption and if not used in greater strength than 1 to 5000 or 1 to 10,000. The amount of irritation will vary with the strength of the solution, hence solutions of 1 to 1000 and 1 to 2000 should always be used guardedly.

On an incised wound it should seldom or never be used if a primary union is desired; hence in plastic work, pure hot water should have preference over the weakest of the bi-chloride solutions. Its action on a living tissue is that of an escharotic, hence in incised wounds the surgeon can defeat a primary union by bathing the surfaces of the wound in a strong solution by a slight contact.

In removing decomposing masses from the vagina and uterus, a solution of 1 to 5000 is sufficient; stronger solutions are unnecessary.

In curetting the uterus, in the operation of divulsion, in the removal of intra-uterine growths and in repair of the cervix, the cavity of the uterus should first be thoroughly washed out with a solution 1 to 5000. After this is well done sterilized hot water is sufficient for subsequent cleaning of the field of operation.

In office work it will be found a safe practice to wash out the uterus and vagina with a bi-chloride solution 1 to 5000 before using instruments or making local applications within the uterine cavity.

In operative work the field of its application should be guarded and limited to those conditions which strictly call for the employment of a germicide. It can have little or no value where safer germicide agents are available, hence it is less efficient than heat for sterilizing instruments, sponges, ligatures and dressings. As an after-dressing it is of less value than iodoform or sterilized gauze.

It is, therefore, possible to limit the use of the bi-chloride solution to a few important conditions where its value is positive and to discard its use in conditions where its value is uncertain and its danger is more or less apparent. No surgeon will speak disprovingly of an agent of such real value as the bi-chloride of mercury, yet every prudent surgeon will recognize the limit which should be placed upon its indiscriminate use.

These suggestions have been offered as a protest against a tendency which has arisen in the professional mind to rely too implicitly upon this germicide in all forms of surgical procedure.

The dangers of the drug may be illustrated with the following case:

In December, 1893, I had occasion to curette the uterus for uterine hæm-

orrhage due to an interstitial fibroid growth. I carefully washed out the uterus with a solution of the strength 1 to 5000. After this I curetted the cavity thoroughly and again washed out with the same solution.

Fearing a subsequent hæmorrhage and not having sterilized or iodoform gauze conveniently at hand, I wrung out the ordinary gauze in the same solution and then introduced it into the vagina as a tampon. Twenty-four hours later I removed the gauze and then washed out the vagina with hot water containing 5 per. cent., of carbolic acid. The wound looked well and there was no subsequent trouble from this source. On the third day the patient complained of having a sore mouth; upon examination I found a well-marked case of ptyalism, which obstinately persisted for ten days.

Mercury had not been used in any other form and absorption had occurred from the gauze which had been wrung out in the bi-chloride solution.

This patient had this very marked idiosyncrasy, but the lesson was sufficient to remind me that solutions of the drug even in this form should not be used for such a purpose. In obstetric practice the bi-choloride solution should be used with caution, if used at all. In my own opinion, boiled water reduced to a proper temperature is safer and equally as efficient as an agent for flushing out the vagina during the puerperium. When infection has taken place it is a far better practice, in my experience, to introduce a speculum and clean out the uterus with a curette or applicator. The same principles will apply to abortions and miscarriages.

Society Reports.

CLINICAL SOCIETY OF MARYLAND.

STATED MEETING HELD FEB. 16TH, 1894.

The 291st regular meeting was called to order by the Vice-President, Dr. Herbert Harlan.

Dr. Robert W. Johnson read a paper on "Strangulation of the Testicle Due to Twist of Spermatic Cord" and exhibited specimen.

Dr. Wm. S. Gardner followed with a paper on "The Conservative Surgery of the Uterine Appendages:"

Last year in a paper read before the Medical Journal Club I reviewed the literature bearing upon the treatment of diseases of the appendages and endeavored to show that a large number of cases of what are now known to be salpingitis were not only relieved but permanently cured by purely medical treatment. The basis of the treatment was that inflammation of the Fallopian tubes, like other inflammations, have a tendency to recovery if the diseased organ is put at rest.

After the advocates of this rational form of treatment, came those who have gone so far as to say that all diseased tubes and accompanying ovaries should be removed; that on account of their diseased condition they were useless so far as their functions as generative organs were concerned, and hence the woman was better without them. Many of these operators have not taken into consideration the question of whether the function of menstruation should or should not be retained by the preservation of healthy ovaries or parts of healthy ovaries.

Now a third class is coming forward who say: 1st. Do all that can be done by mechanical and local treatment; then, when operation is necessary, do all you can to preserve the function of menstruation and the possibility of conception.

Dr. Gardner then quoted the opinions of several eminent authorities as to the effect of castration upon women, and made a review of a number of cases treated by these men in the conservative manner, concluding with the following statements:

1st. Women are better mentally and physically for the maintenance of menstruation and ovulation up to the period of nature's menopause.

2nd. Resection of the Fallopian tube when it does not contain pus is a practical operation.

3rd. When the tube is so diseased as to demand removal, the ovary being healthy, the tube should he removed and the ovary left.

4th. Cysts of the ovary do not demand its removal in all cases, good results having been reported from resection.

5th. Adhesions do not demand removal of tubes and ovaries, unless they are so dense that in breaking them the appendages are injured.

6th. In all cases of chronic disease of the tubes the uterus should be curetted and packed with gauze.

7th. Enucleation of fibroid tumors leaving the ovaries is better than to remove the ovaries and leave the fibroids.

8th. Conservative operations upon the appendages, instead of rendering the patients hopelessly barren, have cured a considerable number of cases of sterility.

Dr. W. P. Chunn: I believe in conservative methods and would try mild means before proceeding to radical operations. When the case is such as to demand a laparotomy, it is usually necessary to remove the appendages.

Dr. B. B. Browne: Conservatism seems to be the order of the day. I am satisfied that curetting and drainage frequently bring about such good results as to remove the necessity for laparotomy. It is always best, if conditions permit, to try the easier method first.

Dr. J. H. Branham: It is best to try easy methods and to save all we can to the woman, but in cases requiring laparotomy, conservatism of operation may be carried too far. I can hardly conceive of the epithelium being restored in a tube which has been the seat of suppurative inflammation. The chances of restoring the tube to its natural functions by delay are very slim. If you are sure you have pus tubes it is best to operate. Delay only leaves you in danger of extension.

The typical ovarian cyst, with chocolate-colored fluid and hypertrophied tissue, is essentially cancerous and is only quiet for a time. If you leave a piece of this you are pretty sure to have, sooner or later, general infection. As for ovary with multiple cysts, the pain is very great and if you must operate for relief it is best to take out the whole ovary, otherwise you only leave chance for further cyst formation.

As for the operation unsexing a woman, it is not a universal opinion that there is such a great change.

Dr. Gardner, in closing the discussion, took exception to Dr. Branham's remarks about the cancerous character of ovarian cysts.

Dr. Hiram Woods said, in his paper "Is Ophthalmia Neonatorum always Curable?": Last December, at the Presbyterian Eye and Ear Hospital, a baby came out of an attack of ophthalmia neonatorum with scarred cornea. Both eyes will have useful but never perfect sight. In the summer of 1892 I saw another case with one cornea badly damaged. In both cases the home cleaning was bad and in one the mother failed for several successive days to bring the child to hospital for silver treatment. In the Transactions of the American Ophthalmological Society for 1893 is an account of a case lost by Dr. Randall, of Philadelphia, despite the most careful treatment, and it reminds me of a baby I saw 3 or 4 years ago—blind—who had been treated correctly from the beginning. In the light of these cases I have reviewed my experience and observation of this disease with special reference to the question, Is it always curable? The experience of Dr. Randall and others compels a negative answer. But such cases are exceptional. The vast majority can be cured by routine treatment in from 3 to 14 days. A few cases are not helped by cleaning and the 1 or 2 per cent. silver solution. Why? Frequently I believe because of rough handling. The disease is seen usually among the poor; trained nurses cannot be employed and half-hourly cleansing is necessary. Unskillful attempts to clean the conjunctival sac often result in injury. Sometimes cleanliness and daily use of 1 or 2 per cent. of sol. silver seem to have no effect upon a case. Should the silver be discontinued or employed in stronger form? As nearly as I can give the clinical condition demanding the discontinuance of silver it is: conjunctival purulency, unaccompanied by lid infiltration, papillary swelling of conjunctiva and the deep-red color seen in severe cases. There comes a time in a certain percentage of cases when, although purulency continues, nitrate of silver will not cure. In these cases it makes little difference what you use besides cleanliness, so the silver is stopped.

As for stronger silver applications, they are only *rarely* called for, and should never be used save by a skilled hand. The symptoms calling for it are: profuse discharge of pus, swollen infiltrated lids, the rugous hypertrophied conjunctiva and the failure to respond to a weak solution. Children of premature birth, those relying on artificial food, or those of weak constitution, form a class of cases in which prognosis is grave. Finally, I wish to protest against the use of cocaine in this disease to allay pain. Such practice is a deliberate courting of trouble.

Dr. E. J. Bernstein: I have met with one case which resulted badly despite the fact that I pursued the usual treatment and had a trained nurse to look after details.

Dr. R. L. Randolph: I have always noticed that the disease is most virulent in ill-fed or diseased children. I have always looked upon the affection as a modified form of the gonorrhœal ophthalmia of adults and agree with Dr. Woods as to the treatment.

Dr. R. B. Norment: It strikes me that the cardinal point is to get at the treatment early. I have kept the eyes clean and used sol. bi-chloride 1 to 6000 freely. I do not consider silver nitrate safe except in skilled hands. Bi-chlo-

ride can be used by any one without danger and my results have been good.

Dr. H. Friedenwald: In some patients this disease is very slight and will get well without treatment other than cleanliness. It is surprising to me that the cornea is not more frequently attacked, when we consider its likelihood in the similar disease of adults. Silver nitrate should be applied to the lids. *Dropping* it upon the eye may cause opacity by cauterization. Bi-chloride has been tried often, but does not compare in value with silver. In test cases where it was used in one eye and silver in the other, the latter produced the most prompt and best results by far.

Dr. Woods: Eyes have been lost by some of the most skillful oculists, as Knapp, Andrews, Randall, &c. The vast majority of cases are curable by early and proper treatment.

In Dr. Norment's cases the point was cleanliness. I think 1 to 6000 bi-chloride is no better than water. I doubt if that solution would kill the gonococcus were it present. The reason for not using cocaine is that it produces exfoliation of the cornea, and thus opens the way for the germs. It is pretty generally recognized now that other secretions than gonorrhœal may cause ophthalmia neonatorum.

H. O. Reik, M. D., Sec'y.
525 N. Howard St.

OPIUM AND ITS OPPONENTS.

Surgeon-General Sir William Moore trenchantly defended the dietetic use of opium at the Society for the Study of Inebriety on February 8th. Dr. George Harley spoke on the exaggeration of many of the statements put forth by anti-opium advocates; Brigade-Surgeon Pringle and Dr. Lansdell took the opposite side. The President, Dr. Norman Kerr, said that it seemed to him that there had been exaggeration by both parties in the controversy. In some respects opium inebriety was more grave than alcoholomania. It was less easily cured, but on the other hand, it had not been shown to have produced the serious organic lesions arising from alcohol. While alcohol lowered, opium raised the temperature of the body. In the East, though excess in opium varied in different countries—being less prevalent in India than in China—opium could be taken with much greater immunity than in England or America. It was a fallacy to suppose that the majority of opium users in the East were slaves to the drug. As with alcohol in Britain, the majority were limited consumers, being less than 10 per cent. Yet, after every allowance for exaggeration, it appeared to Dr. Kerr that, from a medical and scientific point of view, opium and alcohol were poisons whose useful and beneficial employment was restricted to therapeutic use.—*Brit. Med. Jour.*

The Swiss Statistical Bureau gives the following particulars as to the medical profession in Switzerland: In 1890 the total number of medical practitioners was 1,530, being a proportion of 5.2 per 10,000 of the population; in 1891 the number was 1,557, or 5.3; and in 1892, 1,634, or 5.5 per 10,000 inhabitants. In 1893 the total number of doctors was 1,656, or 5.5 per 10,000 of population.

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BALTIMORE, MARCH 17, 1894.

Editorial.

THE STATE CARE OF THE INSANE.

Attention has more than once been called by the JOURNAL to the fact that the indigent insane of this State are inadequately provided for, and to the urgent need of better asylum provisions for this unfortunate class of citizens. The Committee having the interest of these people at heart, through its chairman, Dr. G. H. Rohé, has issued the following circular, which we very cheerfuly publish in full. The matter is of such importance that we would urge the cooperation of the profession of the State in the manner suggested by the Committee. A letter or personal interview with the members of the Senate and of the House of Delegates from medical men residing in the various districts throughout the State would secure the passage of the bill now pending. The financial condition of the State should not be regarded as a barrier to this appropriation. The State of Maryland is amply able to provide for its indigent insane and it will be a disgrace to reject this bill on any such ground as that of economy. The bill is just in its demands upon the State and it should become a law.

"The Committee on State Care of the Insane, appointed at the semi-annual meeting of the Faculty at Annapolis, have, after mature deliberation, agreed to indorse the bill introdueed into the Legislature of Maryland by Senator Hubner, of Baltimore County, providing for the purchase of land, and the construction of an additional hospital for the insane in this State. Several amendments suggested by the Committee have been accepted by Senator Hubner. The bill has passed the second reading in the Senate, and will soon be called up for its third reading in that body, and if passed will be sent to the House of Delegates.

"The bill provides for the appointment of a Board of Managers, of which the Governor shall be, ex-officio, a member, whose duty it shall be to purchase a tract or tracts of land of not less than five hundred acres, accessible to railroad or railroad and water transportation. Buildings shall be erected on the cottage plan and patients shall be received as soon as the necessary provision for their care is made.

"This bill appropriates seventy-five thousand dollars for the purchase of land and the erection of buildings, and twenty-five thousand dollars for the support of the patients received into the institution.

"While the Committee feel that this measure is inadequate to give the relief

demanded by the condition of the indigent insane in Maryland, they are also aware that in the present financial condition of the State, more liberal appropriations cannot be expected. The committee are of opinion, however, that the opportunity should not be allowed to pass without an attempt to give some relief to this unfortunate and afflicted class of our citizens.

"The committee therefore beg you, both by personal solicitation and writing, to interest the representatives of your county in the Senate and House of Delegates in this bill, and endeavor to secure a favorable report from the Committee on Ways and Means of the House, and a unanimous vote for it on its final passage in both branches of the Legislature."

THE PROGNOSIS IN SOME FORMS OF BACILLARY PHTHISIS.

The diagnostic importance of tubercle bacilli is at the present time rarely doubted, but little attention seems to have been paid to the prognosis of such cases in which the bacilli are found in abundance. Dr. G. Hunter Mackenzie (*British Medical Journal*, March 3rd, 1894), after a prolonged study of this subject, says that there are cases in which the presence of these organisms in the sputum heralds early death, and cases, on the other hand, in which they appear to have but slight appreciable effect on the general health of the individual. In general, these two classes of cases may be distinghished from each other by the presence or absence of fever, and by the locus of the bacilli. Whilst these bacilli are frequently accompanied by fever, there are cases in which there is little or slight rise of temperature and in which the bacilli are abundant. It has been found that in these non-febrile cases where bacilli have been present for seven, eight, nine years and longer, the general health was fairly good and there was no marked evidence of growing worse, except a tendency to colds and catarrhs.

Again Dr. Mackenzie thinks it is an axiom that the higher up the locus of the bacilli in the respiratory tract, the more unfavorable the prognosis. It is a much more serious affection in the larynx than when the lungs are affected; indeed, a simple chronic laryngitis may become tuberculous. Again, he finds that syphilis and phthisis often meet in the larynx. Notwithstanding these facts the presence of tubercle bacilli in the sputum, when of pulmonary origin and not attended with pyrexia, may not mean immediate death and perhaps may indicate an extended life, still it is desirable to effect a cure if possible. Such cases should select a suitable climate and stay there, not one, two or three months, but for years at a time and perhaps for life.

THE NEED OF A HOSPITAL FOR CONSUMPTIVES IN BALTIMORE.

While a specific for the cure of tuberculosis does not seem to be very near at hand, medical societies and health boards are taking action on the prevention of this disease and its restriction. By a system of careful registration with proper disposal of the sputa and whatever else contains the bacillus, tuberculosis can be materially restricted and

kept from those who inherit a susceptibility to it; but for those who do not escape the disease, a special hospital is needed in every city, and this is true of Baltimore.

Baltimore has a large number of hospitals, large and small, public and private, general and special, and many of these receive and care well for the consumptive cases brought to their doors, but with all this good care, such cases do not get on as well as in a special hospital. In a hospital where diseases of the chest are alone treated, consumptives in all stages will of necessity be brought together, and while many of them will die, a few will recover because of the special care, and of those that die, many will have their sufferings alleviated and their most painful symptoms mitigated.

It has been urged against this that a hospital where so many consumptives are collected would become a centre of infection and would spread the disease. This may have an element of truth in it, but this danger could be in part prevented by a proper disposal of the sputa. Such a hospital should be in the suburbs where fresh air and plenty of sunshine are more plentiful than in the crowded city.

Reviews, Books and Pamphlets

The National Dispensatory. Containing the National History, Chemistry, Pharmacy, Actions and Uses of Medicines, Including those recognized in the Pharmacopœias of the United States, Great Britian and Germany, with numerous References to the French Codex. By Alfred Stillé, M. D., L.L. D., Professor Emeritus of tho Theory and Practice of Medicine in the University of Pennsylvania; John M. Maisch, Ph. M., Phar. D., late Professor of Materia Medica and Botany in Philadelphia College of Pharmacy, Secretary to the American Pharmaceutical Association; Chas. Caspari, Jr., Ph. G., Professor of Pharmacy in the Maryland College of Pharmacy, Baltimore, and Henry C. C. Maisch, Ph. G., Ph. D. New (5th) edition, thoroughly revised according to the new United States Pharmacopœia (7th Decennial Revision, in 1894). In one magnificent imperial octavo volume of 1910 pages, 320 elaborate engravings. Cloth, $7.25; leather, $8.00. With Ready Reference Thumb-letter Index, cloth, $7.75; leather, 8.50.

There are few books so comprehensive in their scope and so useful in their contents as The National Dispensatory. It is a vast storehouse of medical information alike invaluable to the physician and druggist. Since its first appearance fifteen years ago it has been recognized as a standard authority, accurate, convenient and complete in its information.

The last edition (5th) has been revised and rewritten to bring it abreast with the changes and improvements which have been made within the last few years. The volume is rich in chemical and pharmaceutical information, with data, formulas and tables gathered from all official sources. It is illustrated whenever illustrations are necessary to aid in description of drugs or apparatus. It offers a complete and trustworthy ency-

clopedia of materia medica, therapeutics, pharmacy and the collateral sciences.

The size of the work may be comprehended by the fact that it contains 1900 printed pages.

Of the accuracy of the work it is almost needless to speak. It contains the latest and ripest knowledge of that pharmaceutical savant, Professor John M. Maisch. Professor Charles Caspari, Jr., of our city, is already widely known by reason of his connection with the revision of the U. S. Pharmacopœia, and likewise by his occupancy of the Chair of Pharmacy in the Maryland College of Pharmacy. The Therapeutical portion of this edition continues to enjoy the critical knowledge and judgment of its author, Professor Alfred Stillé, M. D., of the University of Pennsylvania.

Medical Progress.

THE BEST METHOD OF SLAUGHTERING ANIMALS.

At a recent meeting of the Berlin Physiological Society, Dr. Dembon, of St. Petersburg, read a paper "On the Best Method of Slaughtering Animals," which gave rise to an immediate discussion. Two methods are in use in the central slaughterhouses of the Berlin "Viehhof." One consists in stunning the animal by blows on the head before killing it; the other, in sudden severing of the carotids without any previous stunning. This, as is well known, is the old Jewish ritual method of slaughtering. Dr. Dembon has carried out a series of experiments on animals in Professor Munk's physiological laboratory in Berlin, and his results go to prove the superiority of the Jewish method. To stun completely a powerful animal such as an ox, as many as eight or nine blows are sometimes required; whereas the loss of blood from the brain that follows the severing of the carotids produces unconsciousness almost instantaneously. Again, where the animal is stunned by blows on the head, there is paralysis of the vasomotor centre, and in consequence an enlargement of the blood vessels. This prevents the blood from escaping quickly and completely. Now, it is a fact well known to butchers that raw meat will not keep fresh unless the blood be permitted to escape as freely as possible; and many of them for this reason habitually employ the Jewish method of slaughtering, which, by the strong reflex convulsions that follow the sudden opening of the large vessels of the throat, favors a speedy and complete escape of the blood. These reflex convulsions also cause the production of lactic acid in the muscles as proved by Du Bois-Reymond in 1859, which probably acts antiseptically.—*Brit. Med. Journal.*

WHAT VALUE HAS THE MICROSCOPE IN EXAMINATIONS FOR GONORRHŒA?

The results, both positive and negative, are very certain and satisfactory in making a diagnosis of gonorrhœa in either sex, by the microscope. Professor A. Neisser (*Deutsche Medicinische Wochenschrift*, Nos. 29 and 30, 1893) issues the following important conclusions on this question (translated by Dr. G. A. Himmelsbach, Buffalo, N. Y., in the *Buffalo Medical and Surgical Journal*, March, 1894):

1. It cannot be doubted that the gonococcus is the cause of gonorrhœa.

2. The diagnosis of gonorrhœa in man or woman can, in many cases, be made by observing only the clinical manifestations, without searching for the gonococcus.

3. In many cases, especially those inclined to a chronic course, with few subjective and objective manifestations, the diagnosis is dependent upon a demonstration of the presence of the gonococcus.

4. For this very reason, in all cases of "cures," the investigation for the gonococcus is indispensable to solve the question, whether the discharge is still contagious, or whether we have to deal with only a morbid process, the remains of a former contagion.

5. At all events, the therapy should be based upon the existence or non-existence of the gonococci, and a search for the same should be made not only before, but also during, the whole progress of the treatment.

6. In most cases, microscopic investigation for the gonococci should be sufficient, and, on account of the difficulties which sometimes arise in cultural methods, the progressive treatment is assisted by this means only in particular cases.

7. In every instance where positive results (gonococci) are found, there can be no doubt as to the usefulness and necessity of this means of diagnosis.

Negative results should not be conclusive, because we know of the possibility of gonococci being deeply concealed in the tissue, or in the lamina or folds (invaginations), while at the same time the superficial secretions of the mucous membrane, which we examine, may contain gonococci so few in number as to escape detection. The certainty of their existence, however, will be proven by more frequent examinations for them, and by artificial cultural observations.

The clinical manifestations should always be studied and their relationship strengthened by the use of the microscope.

8. If we have to do with gonorrhœa in married people, then bath husband and wife should be examined, and, if necessary, both should undergo a course of treatment.

GUAIACOL AS AN ANTIPYRETIC.

Guaiacol has been used, as is well known, as a substitute for creosote in a large number of cases of pulmonary disease where that drug was indicated, and, so far as we know, has given so much satisfaction that it bids fair to supplant creosote in the treatment of many of these affections. Within the last few months the profession has begun to recognize the fact that it possesses other powers than those of an expectorant and antiseptic, or stimulant of the mucous membrane, and a number of prominent physicians have employed it for the reduction of high temperature.

Two of the most notable contributions which have been made upon this subject—the clinical lecture of J. M. Da Costa and the interesting paper of Robilliard—are particularly worthy of note. In both instances these clinicians used the drug externally upon the skin of the thigh, abdomen, or chest, either by means of rubbing or by painting it on with a camel's hair brush. After it was applied to the skin it was thought advisable in some cases to place an impermeable dressing over it in order to prevent

evaporation. As a result of the application of 20 to 50 minims of guaiacol in this manner, it has been found that the temperature of malarial fever, typhoid fever and pneumonia rapidly falls as much as seven degrees in the course of an hour or two. Da Costa asserts that this rapid reduction of temperature is not accompanied by any marked disturbance of the nervous system or any evidences of collapse, not even by a very profuse sweat, neither does there appear to be a very active chill, although sometimes slight chilliness is experienced. The drug does not seem capable of holding the temperature down for any length of time, but it has been found perfectly safe to employ it as often in the twenty-four hours as is necessary to prevent pyrexia appearing with severity. Da Costa suggests that in many instances it may take the place of the cold bath, so far as the reduction of the fever is concerned; but whether or not guaiacol, on further use, proves to be a valuable antipyretic, we are sure that the therapeutic results obtained by the cold bath cannot be substituted by this means of treatment, since the cold bath undoubtedly exercises a therapeutic effect over and above that produced by guaiacol. We do not wish to be understood as stating that Dr. Da Costa believes that the cold bath should not be retained. He simply suggests that guaiocol be employed in its place when, because of the lack of attendants, the bath treatment cannot be well carried out, and because he believes that guaiacol is preferable to the antipyretics derived from coal-tar in the reduction of temperature. In the treatment of hectic fever of tuberculosis, J. Solis-Cohen and others have found this drug of equal value. It may be painted over the chest in the area occupied by the pulmonary disease, but is said to be contraindicated in cases in which there are hæmorrhages or well-developed cavities.—*Therapeutic Gazette.*

THE TREATMENT OF PULMONARY TUBERCULOSIS WITH PROFESSOR KOCH'S TUBERCULIN.

Karl Von Ruck (*International Medical Magazine*, February, 1894) refers to his earlier article, in which he reported (*Therapeutic Gazette*, June 15, 1891) twenty-five cases of pulmonary tuberculosis treated with Koch's tuberculin. He then gives the present condition of these patients.

Class A, of five cases reported, all recovered, or one hundred per cent. of recoveries.

Class B, of seven cases reported, six made a final recovery, and one improved, making eighty-six per cent. of recoveries.

Class C, thirteen cases were reported, six of which have improved, while seven have died.

After giving some precautions in regard to selection of patients and making of observations while they are under treatment, he gives his method of administration of tuberculin as follows:

"Beginning with one-twentieth of a milligramme as a trial dose, to which I have never seen a response, the next dose is one-tenth of a milligramme, and the increase is thereafter one-tenth until one whole milligramme is reached; then I increase one-fifth of a milligramme until two milligrammes are reached; next one-half milligramme up to ten; from ten to twenty milligrammes, and thereafter five milligrammes at a time."

He has treated one hundred patients with between six and seven thousand injections, and he therefore concludes that tuberculin is no longer on trial as an experiment, but, on the contrary, its effects are as reliable and as uniform as one could expect them to be under the great variety of individual conditions, such as constitution, stage of the disease, organs involved, or complications present.

THE COLD DOUCHE AND TAXIS IN STRANGULATED HERNIA.

Raiford (*American Medico-Surgical Bulletin*) claims that ninety per cent. of the cases of strangulated hernia can be reduced within a few minutes by the method of treatment which he describes. The operator should be seated to the left of his patient, and should perform taxis while an assistant pours, from a height, cold water over the tumor. With the index and middle fingers he first finds the constriction, the exact localization of which is materially aided by traction made upon the uppermost part of the tumor with the right hand. This should be done simultaneously with the palpation of the stricture and with the first application of the cold douche. The constriction found, the fingers are gently inserted beneath it, where they are held with a slight pull upward, while the tumor is lifted upward and pressed inward with the right hand, the cold douche being continuously applied. The author has in his cases placed the patient in the dorsal position, shoulders lowered, hip elevated, thighs flexed at somewhat more than a right angle with the body.

Anæsthesia by inhalation or locally has never been found necessary, for reduction is accomplished in the time required to get the patient anæsthetized. In a few cases chloroform has been given, and a hypodermic injection of morphine or cocaine in two cases.—*Therapeutic Gazette.*

AN EARLY SIGN OF PNEUMONIA.

Morison (*Lancet*), in several cases presenting the general symptoms of pneumonia in the absence of the ordinary physical signs, has observed a jerky expiration over limited area, in which he subsequently found developed the usual signs of pneumonia. This jerky expiration is believed to be the first physical sign developed, and can be heard soon, if not immediately, after the rigor, before dulness or crepitation appears. The sign is more distinct in children, but has also been observed in adults. It is suggested that the phenomenon may be due either to the primary congestion interfering with the elasticity of the lung or to the better propagation of the heart-beats through a more readily conducting medium than the healthy lung.—*Canadian Lancet.*

CONSERVATIVE TREATMENT OF PYOSALPINX.

Kollock (*International Medical Magazine,* February, 1894) calls attention to the changes made in the treatment of pyosalpinx within the last year or two, and mentions cases treated by the conservative method which have been reported by Polk, Pryor, Krüg, Boldt, and Dudley.

He claims by this method the tube and ovary of the non-affected side, and also the diseased tube may often be saved. He says further, "My experience, while limited compared to that of others men-

tioned, has been sufficient to convince me that the conservative system of practice is bringing us to that period when the mutilations of women, once supposed to be necessary, should cease. This, we think, will be accomplished; as we also believe that abdominal surgery in the hands of such men as Sänger, Porro, Kelly, Price, and others, will put an end to the barbarous and murderous practice of resorting to craniotomy and embryotomy on the living fetus."

He then reports four cases of pyosalpinx, three of which were entirely relieved without resorting to cœliotomy.

LIABILITY FOR INJURIES WHEN DEATH FOLLOWS SURGICAL OPERATIONS.

When death results from a personal injury as its direct and proximate cause the party responsible for the latter is liable for such death. In the case of Rettig *vs.* Fifth Avenue Transportation Company, recently decided by the Superior Court of New York City, General Term, which was an action brought to recover damages for alleged negligent acts causing injuries resulting in death of the injured person, the defence was raised that death was rather caused by a surgical operation than by the injuries complained of. One of the attending physicians at the hospital to which the injured man was taken testified that he died from the result of his injuries, that his condition necessitated a surgical operation, which was skilfully performed, and that he died of the shock that followed. This evidence is declared admissible, and the court holds that the surgical operation and the consequences flowing from it in no manner relieved the transportation company from liability for the death as a result of the injuries inflicted by its negligence. Indeed, the court shows that it has been held that when a person who, through the negligence of another, has received an injury which, without a surgical operation, would cause his death, employs a competent and skilful surgeon, by whose mistake the operation is not successful, and the patient dies, the wrongdoer is not shielded from liability by the surgeon's error; and this although the operation is the immediate cause of the death.—*Med. News.*

TREATMENT OF CHRONIC ULCER OF THE STOMACH.

The great difficulty of properly treating stomach ulcers in private practice, owing to the careful dieting necessary, has led to a new mode of treatment. During the past four years Dr. Stepp (*Therapeutische Monatshefte,* November, 1893) has used chloroform-water with bismuth subnitrate. The latter he does not consider necessary. He gave only the following formula:

℞.—Chloroform . . 1 part,
Aqua . . . . 150 parts,
Bismuth subnitrate . 3 parts.
Sig.—1 to 2 spoonfuls hourly.

Dr. Stepp remarks that chloroform taken internally as aqua chloroformi is never an anodyne and has not the slightest pain-alleviating property. He gives the history of seven cases chosen from a very large number. As soon as the diagnosis is confirmed, the chloroform treatment can be begun. The refreshing taste of the chloroform-water combats most actively the nausea and thirst after the bleeding, and any tendency to further bleeding is stopped by the styptic properties of the chloroform. In new

as well as long-standing ulcers there is soon a marked improvement; the color of the face improves vastly.

All the patients said that each time, after taking any, they felt a burning in a certain part of the stomach, doubtless the place of the ulcer, which disappeared after eight to ten days.

He never found any harmful influence upon the rest of the body.—*Therapeutic Gazette.*

THE SEDATIVE ACTION OF DUBOISINE IN CONTINUED DOSES IN INSANITY.

Dr. E. Marandon De Montyel, in his service at Ville-Evraud, has administered this remedy as a sedative in continued doses during the day to thirty-five patients. The results have been marvellous, and in cases of agitation it often changes violent excitement into a perfect tranquility. Unlike hyoscine, it does not paralyze the voluntary muscles, nor does it, like somnal, narcotize the patient. Its action is not immediate, for it may not be complete until the second, sometimes until the third day. When its effect has been obtained it persists quite regularly, so that ordinarily the patients do not experience regularly good and bad days. Further, it frequently happens that the improvement may continue for several days after the cessation of the medicine, and a period of calm, more or less prolonged, may be established. An important fact in its administration is, that when once a tolerance is established the patients ordinarily fail to be influenced by the drug, no matter how large the dose, and the marvellous sedation of the first days cannot again be obtained. The dose employed has been from one-thirty-second to one-sixth of a grain, in two equal portions at nine in the morning and at three in the afternoon, the patients receiving their food at seven and eleven in the morning and at five in the afternoon. The remedy appears to have an unfavorable action upon nutrition.—*Amer. Jour. Med. Sciences.*

Medical Items.

Dr. Milton N. Taylor has been elected physician to the City Jail.

Dr. and Mrs. Richard H. Thomas will sail for Europe next week.

There are 801 medical students in the Medical Department of the University of Pennsylvania.

The death of Professor William Leishman, the distinguished Glasgow obstetrician, is announced. He was in his eightieth year.

The Medical Journal Club, composed of some of the younger physicians of this city, held its annual banquet last week.

The Baltimore University Hospital of North Bond Street has asked the Legislature for an annual appropriation of $5,000 for two years.

Small-pox is so prevalent in Chicago that measures are advocated for a quarantine of fifteen days for suspected cases.

The Trustees of the Johns Hopkins Hospital are considering the advisability of lengthening the course in the Training School for Nurses from two to three years.

The bill appropriating $75,000 for building an asylum for the indigent insane in this State has passed the Senate and awaits the action of the House.

The physicians of the United States now number 118,453; New York leads, with 11,171; Pennsylvania has 9,310, and Illinois ranks third with 8,002.

Dr. D. H. Williams, a colored physician of Chicago, has been appointed to succeed Dr. Purvis, of Washington, as superintendent of the Freedmen's Hospital, at that place.

According to the latest reports, cholera has broken out at Constantinople and at Tripoli, but no fresh cases have been reported at St. Petersburg for several months.

Senator Hubner has introduced a bill in the Maryland Legislature to form a special commission of five to select a site for the colonization and care of epileptics of this State.

The New York Hospital Saturday and Sunday collection amounted a year ago to $58,000; it is hoped this year to bring the amount up to $70,000. There are over thirty hospitals in the association.

The total collections of Hospital Saturday in 1893 in Baltimore were $590.-39, and those of Hospital Sunday were $1,289.82. For both days the total was $1,880.21, which is about $250 less than usual and $800 less than the maximum collections.

Under the new law requiring early notification of cases of ophthalmia neonatorium, a conviction of neglect has recently been secured in a case in New York. A similiar law has already passed one branch of the Ohio Legislature and is likely to be soon placed on the statute book of that State.

Some time ago Pennsylvania passed a law prohibiting any but registered pharmacists from compounding medicines. A physician in that State was charged with breaking the law and at the trial was acquitted, the judge giving the opinion that such a law was unconstitutional and framed in the interest of the pharmacists.

A board of medical officers will meet Monday, April 16, 1894, in Washington, D. C., for the purpose of examining candidates for appointment to the grade of Assistant-Surgeon, in the Marine Hospital service. For further information address, The Supervising Surgeon General, U. S. Marine Hospital Service, Washington, D. C.

Building Inspector Oster, who, with the Health Commissioner, has been inspecting the system of heating and ventilation of the public schools in New York, has returned home. It is expected that the public school buildings of Baltimore will be thoroughly equipped with efficient systems of heating and ventilation and there will likely be some competition when the invitation for bids is made.

The will of Rev. William C. Moseley, of Newburyport, Mass., bequeaths $50,-000 to Harvard College, to endow a professorship in the Medical School. Other bequests in the will were $20,000 to the Massachusetts General Hospital, for beds in memory of his son; $10,000 to the Boston Lying-in Hospital; $10,-000 as a trust to the Perkins Institute

for the Blind; and $10,000 to the Anna Jacques Hospital, of Newburyport.

More than a thousand papers are said to be upon the programme of the International Medical Congress at Rome and up to the end of 1893, 4,000 persons had registered as members and paid dues. Although all of these will not be present at the meeting, a large number will come, and in addition to the usual exodus of visitors to Italy at this season, will crowd uncomfortably the Eternal City.

The committee appointed by the Philadelphia Board of Health to consider the advisability of placing tuberculosis in the list of contagious diseases has decided such a radical course was not expedient with regard to this disease. It believes that consumption is an infectious disease, but that a middle course should be pursued, such as registration, disinfection and publication of information with regard to means of prophylaxis.

The Committee on Preventable Blindness, from the Medical and Chirurgical Faculty, was before the House Committee on Hygiene at Annapolis last week to urge the importance of passing the bill compelling midwives and others to report suspected cases of ophthalmia neonatorum. For some unaccountable reason this most important bill has been opposed by some physicians of the State and by some of the more intelligent members of the Legislature, who evidently do not understand the object of the bill.

In reference to the mortality at the hospitals for infectious diseases, Liverpool seems to have obtained an enviable position. The Medical Officer of Health has just issued statistics showing that hospital treatment there has a less mortality than home treatment. Thus in the last three years the Liverpool hospital's mortality of scarlet fever was under 6 per cent., as against nine per cent. of those treated at home; and typhoid shows only twelve per cent. of hospital cases against nearly nineteen per cent. of home-treated patients.

Colonel B. J. D. Irwin, Medical Director of the Department of the Missouri, U. S. A., has been awarded the bronze medal of honor which Congress, by Act passed in 1864, authorized the War Department to confer upon officers or enlisted men for any specially meritorious conduct in action. The act for which the medal is granted was performed almost thirty-three years ago. Colonel Irwin was then a young surgeon serving in New Mexico, where the Apaches were on the war path. The medal is awarded for bravery in fighting the Indians.

New York is imitating Chicago in the proposed office building. This structure will have every convenience for the use of physicians, such as telephones, telegraph office, district messenger service, an agency for trained nurses, mail chutes, steam heat, electric light and motor power. There will be large and easy-running elevators to receive the wheeled chairs which the careful janitor will use to convey the invalids from carriages to the office. The possibilities for such a congregation of medical talent is simply bewildering. There is no mention of a medical school and a diet kitchen on the top floor.

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CONSERVATIVE SURGERY OF THE UTERINE APPENDAGES.

BY WILLIAM S. GARDNER, M. D.,
OF BALTIMORE.

Last year, in a paper read before the Medical Journal Club, I reviewed some of the literature bearing upon the treatment of diseases of the appendages before the time when Dr. Price's remark that "It is no more to open an abdomen than to open a boil," had been adopted as a motto by the aspiring gynecologist. It was shown in that paper that a large number of the cases of what are now known to be salpingitis were not only relieved but permanently cured by purely medicinal treatment. The basis of the treatment was that inflammation of the Fallopian tube, like other inflammations, has a tendency to recovery if the diseased organ is put at rest.

After the advocates of this rational form of treatment, which was not always successful because not radical enough for some conditions, came those who have gone so far as to say that all diseased tubes and accompanying ovaries should be removed; that on account of their diseased condition they were useless so far as their functions as generative organs were concerned and hence the woman was better without them. Many of these operators have not taken into consideration the question of whether the function of menstruation should or should not be retained by the preservation of healthy ovaries or parts of healthy ovaries. But their position is that of the majority of operating

gynecologists, whose opinions are all so well known to members of this Society that it is not necessary to go into further detail regarding them. But now a third class is coming forward who say: first, do all that can be done by medicinal and local treatment; then when operation is necessary do all that can be done to preserve the function of menstruation and the possibility of conception. And it is to the opinions of some of these gentlemen that I wish to call your attention, but before going directly to the operative procedures I think it advisable to spend a short time reviewing the opinions of some operators of large experience upon the effect of castration.

Martin says: "The prognosis of the effect of castration is to be considered as entirely favorable as far as concerns immediate results. If both ovaries are completly removed, menstruation ceases, usually at once, or at any rate in a short time, and the climacteric comes on, often to be sure, with severe suffering, but often without such, so that in general after a time which corresponds to the so-called change of life of normal cessation, the complete disappearance of the menstrual molimina may be anticipated.

"The prognosis is less certain in regard to the final results of the operation; concerning this it must be remembered that want of success may be occasioned by various circumstances.

"The healing of the stumps may take a bad course, which is often only evident at a very late period. Adhesion with the intestines, sloughing of the portions of the pedicles which are beyond the ligatures, discharge of the ligatures; chronic peritonitis; formations of fistulæ; and finally ventral hernia, which are by no means the least of evils, may substitute for the old sufferings, new ones which are no less distressing."

He then goes on to say that in addition to these various ailments that may be acquired by the operation that not infrequently the original disease is not cured.

Goodell, in a recent number of the *Medical News*, gives his opinion upon this subject, and although many if not all present have read the entire article I will read a part of it.

"There are problems in gynecology not yet fully solved, on which I purpose in this paper to give my own individual opinion—an opinion that I do not claim to be infallible, but which is based upon a large experience.

"One question not yet satisfactorily answered is this: What effect upon a woman has the removal of her ovaries? Unquestionably there usually follow the annoyances of the change of life. These, in my experience, are long spun out, because, when menstruation has been abruptly and artificially stopped, the change of life, especially in young women, takes more time to become fully established than when the menopause has been naturally induced. Consequently, years may elapse before the victim of the operation escapes from the perspirations, the flashes of heat, the skin-tinglings, the numbness of the extremities, the nerve-storms, and all other vaso-motor disturbances, the name of which is legion. My experience, therefore, coincides with that of Hegar, who says that "the artificial menopause induced by the operation is often attended with more serious complications

than those which are not rarely observed in the natural change of life.[1]"

"Then again the unwelcome fact cannot be shirked that mental disturbances may by traced directly to the removal of the ovaries as a cause. These are manifested by brooding, by low spirits, by melancholy and even by insanity. Every ovariotomist has met with such painful episodes in his practice. Glavaecke, who has made a study of this subject, goes so far as to declare that "in almost all cases the mind becomes more or less affected, and not infrequently melancholia results.[2]" Keith has stated that ten per cent. of his patients who recover from hysterectomy subsequently suffer from melancholia or from other forms of mental disease.[3] Yet this result must come, not so much from extirpation of the womb, which is merely a muscular bag, as from associated ablation of the ovaries, of which the womb, physiologically, is only the appendage."

After reviewing his former statements as to the effect of castration, he continues:

"A riper experience, of which time was the main element, has led me still further to modify my views on this subject. Unquestionably the natural change of life when fully established, but not until it is fully established, does very sensibly dull and deaden the sexual sense of woman, which ultimately disappears in her long before virility is effaced in man. Nor is the survival of this sense after the menopause so essential to woman, because after the cessation of menstruation she loses the power of procreation, which is retained to an advanced age by man. This is a wise provision of Nature, for, did the sexual sense of the wife outlast that of the husband it could not be gratified. Sensible of these changes, a gifted French authoress makes one of her heroines say, with italicized emphasis: "*Men* may forget the course of years; they may love and become parents at a more advanced period than we can, for Nature prescribes a term after which there seems to be something monstrous and impious in the idea of (our) seeking to awaken love. Yes; age closes our mission as *women* and deprives us of our sex." Now what happens in the natural menopause holds good in that artificially and abruptly produced, with this important difference, that in the latter the sexual feeling is sooner lost. I am willing to concede that in some women, by no means in all, whose health has been so crippled by diseased appendages as to extinguish all sexual feelings, there is, after castration, a partial recovery of the lost sense whenever health has been regained. Yet even in these cases, as far as I can ascertain—for women are loath to talk about these matters—the flame merely flares up, flickers, and soon goes out.

"My own experience would lead me to the conclusion that in the majority of women who have been castrated the sexual impulse soon abates in intensity, much sooner than after a natural menopause, and that in many cases it wholly disappears. This tallies with Glavaecke's conclusion that "in most of the cases the sexual desire is notably diminished and in many cases is extinguished." In corroboration of this statement let me cite, out of my many cases in point, a few of the more salient ones. The wife,

1. British Medical Journal, December, 1886, p. 1280.
2. N. Y. Medical Journal, July 20, p. 73.
3. Ibid., p. 37.

aged thirty-four, of a farmer, so exhausted him by her sexual exactions that his health suffered very seriously. The appendages were diseased and fixed by adhesions. After their removal menstruation and the sexual impulse continued unabated for a little over a year, when the former wholly ceased, and the latter not long after disappeared. Another case was the very ardent wife, aged thirty, of a man who was not so well mated to her. She was sterile and had excessive menorrhagia from a uterine fibroid, for which her ovaries were removed. Menstruation did not reappear, and in less than two years all sexual feeling was lost."

Since pointing out in this way some of the general effects upon the after-life of the women of the removal of the ovaries, I will call your attention briefly to some of the conditions for which healthy and partially healthy ovaries have been removed. These are salpingitis in all forms; retroversions with adhesions, often the results of salpingitis; cystic ovaries and fibroids. From these gentlemen, who are spoken of by Dr. Weir Mitchell as "virulent gynæcologists," the answer to the question, What shall be done for these diseases? comes back promptly in three words: "remove the appendages."

In 1887 at the meeting of the American Gynæcological Society, Polk read a paper entitled "Are the Tubes and Ovaries to be Sacrificed in all Cases of Salpingitis?" And for the first time in this country he answered his own question with a vigorous negative.

In this paper he says, "Had I been asked a year ago whether the tubes and ovaries should be sacrificed in all cases of salpingitis I would have replied yes." But some experiences of the operating table have caused me to doubt the accuracy of the conclusion.

"Among fifty cases treated by removal of the tubes and ovaries, I had noticed some in which the adhesions were a conspicuous feature—there was tubal disease certainly. In some it seemed to be little more than a catarrhal endo-salpingitis, in others there was marked parenchymatous infiltration as well, but in none was there special dilatation of the tube cavity. The outer opening was closed in some, open in others. As to the ovaries, aside from pari-ovaritis, in themselves they appeared normal, but were generally fastened by adhesions in abnormal positions. The mobility of the uterus in common with that of the appendages were restricted, and in some cases it was bound down by adhesions in a retroverted or retroflexed position. All these cases were of long standing, two and three years, and some as much as six and seven years. In comparing the pathological conditions found with the histories, it occurred to me that the adhesions might be the potent factors in the sufferings endured. If this were the case, it was evident that a cure might be effected by simply freeing the imprisoned organs.

"It was plain that the adhesions limited the expansion incident to menstruation, and it was possible that by their restrictive action they had the power of prolonging and perhaps extending the inflammatory action, which but for their presence would cease.

"Certain objections naturally suggested themselves, which I shall briefly state:

"1st. The question of the reformation

of the adhesions. Can this be prevented, and how?

"The prime requisite is to so alter the position of the uterus and its appendages as to separate the ends of the adhesions. When posterior displacements exist, this can be done by means of Alexander's operation, or hysterorrhaphy.

"2nd. Granting the result to health and comfort claimed for this disruption, the next question was the utility of leaving the occluded tube in position.

"For the purpose of procreation, perhaps none; but for the purpose of satisfying a patient's desire to escape mutilation, 'yes.'

"The excuses for mutilation are to save life, to restore and insure health. Do this without mutilation and we answer the requirement; and the object of this paper is to show that it can be done in certain cases."

He then gives the reports of eight cases—all that he had operated upon up to that time. In one a relapse occurred due to the return of the uterus to its abnormal position; the other seven were cured. For experimental work this is certainly an excellent record.

The discussion of this paper is of much interest. Martin, of Berlin, who was present, in speaking of the non-operative treatment said, "That we can succeed in a large majority of these cases I can attest by my statistics, out of which I followed up the cases until the patients were in a state of health. In a very large number I succeeded in reducing the inflammation and tumor of the tube, and I have succeeded also in bringing them to the state of health in which they were able to become pregnant. As to operation, it is not at all certain in my practice. I have performed about 80 operations for salpinx disease, but very seldom has the tube itself given the indication for the operation. Generally it was the spread of the disease to the pelvic organs, particularly the ovaries, which although a severe complication, is not so frequent as to allow us to go on and operate in all cases of salpingitis." In this place Martin means by the word "operate" the removal of the tubes and ovaries, for at that time he had not done the kind of work reported by Polk in his eight cases.

Goodell agreed with Martin that a large portion of cases of salpingitis could be cured without operating, but the evolution that has gone on in his mind in the past six years is shown when we compare what he then said about operating with what he has recently said. In the discussion he used the words, "It struck me that Dr. Polk's practice of breaking up the adhesions and of shortening the round ligaments is too heroic, for, when the cavity of the abdomen has been entered, and the adherent tubes and ovaries have been separated, why resert to a second hazardous operation—that of Alexander's—and give the woman that additional risk? Why not remove the tubes and ovaries? They are now useless appendages, for the woman cannot possibly conceive. Rather than subject the woman to a second operation, I should remove the tubes and ovaries, and trust to their absence to reduce the size of the displaced womb."

In his paper published recently he makes these statements with reference to what he considers strictly operative cases:

"I come now to two cases on which I

urged castration. Perhaps I have had more, but I cannot recall them. Each one had the fixed, sausage-like, tubal tumor on either side. Yet each patient, to my very great surprise, conceived and bore children. The one, a patient of my friend Dr. D. Murray Cheston, first consulted me and afterward a gynecologist of world-wide renown, who corroborated my diagnosis of double pus-tubes, and doomed her, as I had, to hopeless sterility. The puerperal convalescence was stormy and at one time threatening; but she ultimately got well. The other case is a standing joke of my friend Professor Parvin, who knew the circumstances. The woman presented similar characteristics to those of the preceding case, and I urged an operation. This she luckily refused to undergo, and a year or more afterward gave birth to twins. Of course, the rejoinder will be made, that my diagnosis, although shared by other specialists besides myself, was a faulty one. But I can as unhesitatingly reply that had the objector made the examination he inevitably would have followed it by an abdominal section and as invenitably would have removed both appendages, as I certainly should have done had I opened the abdomen.

"Now, in these cases, the pus was either confined to the ovaries, or, as I supposed from the sausage-like form of the tumors, it lay sealed up in the tubes, and the closed-up lumen of one of them was, by returning health, restored to full patency. The possibility of a closed-up tube regaining its bore is, I know, strongly disputed, even ridiculed, and *a priori* reasoning would certainly justify the doubt. If, however, solid uterine fibroids of stony hardness and of several pounds weight will through absorption wholly disappear, as every gynecologist has seen them disappear, why may not the tubal barriers and septa also break down and become absorbed. I have read somewhere, but the reference I cannot now find, that, in order to prevent conception in a case of narrow pelvis, both tubes were ligated, without establishing sterility. On the other hand, great disorganization of the ovaries is not incompatible with pregnancy, for it appears that a very small amount of ovarian stroma goes a great way. Menstruation often continues, however diseased the ovaries may be, and Atlee reports two cases in which one ovary having been removed, the other became so cystic as to need *repeated tappings*. Yet each woman not only menstruated, but conceived and gave birth to a child.[1] In one of these cases, a cyst of the sole ovary, the other having been removed many years previously, was tapped twice before conception, twice before delivery, seven times afterwards and then was extirpated. Robertson [2] mentions a remarkable case in point, which occurred in his practice. He removed both ovaries which were diseased, of one of his patients, yet she afterward conceived and gave birth to a child. His explanation is that he must have left, unwittingly, a scrap of healthy ovarian tissue in one of the stumps. But on the other hand, the ovum could not have descended into the womb, unless the lumen of one tube had reopened at the point where it had been sealed up by the adhesive inflammation set up by the ligature.

1. Atlee: Ovarian Tumors, pp. 38 and 39.
2. British Medical Journal, September 27, 1890, p. 722.

"With regard to the third problem: Supposing simply therapeutic measures fail, and the physician is driven to surgical interference, must he, after breaking up the adhesions, always extirpate the now free uterine appendages? Most surgeons contend not only that the diseased appendage should be removed, but also that both appendages should be extirpated, even if one alone is diseased. This advice is given on the ground that the healthy one is liable in its turn to become affected. My own course, under such circumstances, would be never to remove the healthy appendage unless the menopause had been established already, or unless there obtained a good reason for hastening it on. On the other hand, should both ovaries be intrinsically diseased and their tubes contain pus, I would always remove both uterine appendages in their totality, no matter what the age of the patient might be. Generally, however, the pus is limited to the tubes, and in that case sometimes one ovary, barring its adhesions, which, of course, must be broken, is healthy enough to be left behind. In such a case the tube alone, if possible, should be removed, and not the healthy ovary or the healthy ovaries—if both happen to be sound. Further, rather than wholly remove all ovarian stroma, I should try in such cases to leave behind even a small fragment; for, in several of my cases in which a piece of an ovary, not larger than a bean, was left behind, not any menstrual or sexual changes whatever took place in the woman. Should the uterine appendages be merely adherent, and not intrinsically diseased to any extent, I would, as a rule, during active menstrual life, release them, and perhaps extirpate the worse of the two, but not both of them.

"My reasons for this conservative treatment are that the complete extirpation of these organs, as I have shown before, tends to destroy the sexual feeling, to disturb the mental equilibrium, and to produce prolonged nervous perturbations, all of which came from the abrupt suspension of menstruation. There is yet another excellent reason for this advice: The majority of physicians, and all laymen, look upon a woman deprived of her ovaries as unsexed. Just as castration is in the male, so is the analogous operation in the female deemed a sexual mutilation to which common consent attaches a stigma. No woman would marry a eunuch, and few men would marry a woman deprived of her ovaries. In my own practice I have known several very sad cases of marriage engagements broken off, of marital infidelities, and of bitter estrangement between husband and wife, all of which would have been avoided had one ovary been spared, or, indeed, had a mere fragment of one been left behind."

In the further discussion of Polk's first paper, Dr. Bantock, of London, criticised Dr. Polk's idea of breaking up the adhesions and fixing the uterus forward, stating that while he did not wish to use so strong a term as unjustifiable, that he thought the treatment was incorrect. But before he ceased he related two cases which really strongly supported Polk's views.

Gill Wylie, Emmett, Sutton and others had either had no experience in this line beyond local treatment, or openly stated that they did not think the plan advisable.

At the last meeting of the American Gynecological Society, Polk again read a paper upon this subject. At that time he had operated upon 80 cases in which he had only broken up adhesions, or removed only such portions of tubes and ovaries as were diseased beyond the probability of recovery. His observation is that in a large number of cases of salpingitis, the amount of disease present is insufficient to threaten the patient's life, and in very many the tube as a whole is not sufficiently diseased to forbid its return to efficient duty. Instances of salpingitis in which the parenchyma is involved and thickened form a small contingent of the whole, and if the thickening can be set down to an acute inflammation (as it can in most cases) present at the time of operation in and around the tube, he thinks such tubes should be allowed to remain. But in such cases the uterus should be curetted, and packed with gauze.

In cases of closed infundibulæ he advises that if the tubes contain fluid of any kind, to remove them and also if the closing adhesions are organized, because in these cases the changes in the lining of the tubes is so great as to make the question of their remaining potent more than doubtful. In two cases in which he did a resection of one tube and removed entirely the other one, the woman became pregnant.

Martin, in a recent paper, says with reference to the resection of atretic Fallopian tubes, "It must, of course, be understood that a resection can only be successful in tubes the contents of which are of a serous, non-infectious character, and are free from pus. The surfaces of the tubal walls must be smooth; ulcerative processes naturally exclude resection. If the tubal walls and contents conform to these indications the cavity should be cleansed and disinfected before the edges of the wound of incision are stitched.

He then gives a table of 40 operations where resection of atretic Fallopian tubes after extirpation of the other diseased oviduct was done. Of these, two died; four were not permanently cured, and in one conception took place.

Dr. Robert A. Murry has published a "clinical report of cases of pyosalpinx, treated by uterine drainage, with subsequent conception." In this report he speaks of having treated and cured a large number of cases of undoubted pyosalpinx by dilating, curetting and draining the uterine cavity.

The cases most benefited by this treatment were those in which the tubes and ovaries were almost at the brim of the pelvis in their normal position because these drained more readily into the uterus. He reported in detail three cases of gonorrhœal endometritis and pyosalpinx, and three cases of puerperal origin, all of which he had cured in this way and all became pregnant.

His conclusions are:

1st. That many cases of pyosalpinx are curable without mutilating operations, if the endomitritis is treated by curettage and drainage with strict antiseptic precautions.

2nd. That true drainage of pyosalpinx into the uterus is possible and does occur when the tubes and ovaries are on a level with the uterus, and the uterine end of the Fallopian tubes is patulous or can be made so by treating the uterus.

3d. That uterine curettage and drain-

age should be practised in every case before operation, unless the tubes are very distended, and then, in order to cure the endometritis, which may and often is the cause of the trouble.

4th. That even in cases of pyosalpinx the tubes and ovaries are frequently not useless organs; the proof being that pregnancy occurs.

With reference to ovaries, Polk says his "experience teaches that no matter what is the fate of the tubes, not only should all sound ovaries be left, but every effort should be made to preserve to the woman as much sound ovarian tissue as possible—in this matter following Schroeder's well-known suggestion. It is understood that the essential matter in this question of the ovary is the maintenance of menstruation and ovulation, because of its effect upon the physical and mental well-being of the patient. When the ovary is merely the seat of small cysts which we so commonly see scattered over its surface, ignipunctere with a fine cautery point seems the best procedure. When large cysts prevail eneucleation with subsequent cutting away of the excess of sac-wall and then turning in the edges with the Lembert stitch is the proper course. Or else a V-shaped section may be taken out and brought together with two rows of sutures, the outer introduced after Lembert. He has ten cases, each dating back more than a year, in which he has removed the tube and left the ovary; all these cases are doing well.

Currier reports a case of a sterile woman who had the tube and ovary removed from one side, and half the ovary from the other. In six months she was pregnant. Mann, of Buffalo, reports a similar case.

A. P. Dudley began to do these operations after Polk read his paper in 1887. Two of his patients from whom he had excised portions of the ovaries have become pregnant.

Sippel reports a double ovariotomy in a woman thirty years of age, who had one child five years old and was very anxious for another one. The right ovary was converted into a tumor the size of a child's head, and without a trace of normal ovarian tissue. This was removed with its tube. The other ovary was the size of a goose egg. Along the hilum was a long tract of normal tissue. A clamp was applied above this tract to check hæmorrhage, and the diseased part of the ovary was cut away; the raw surfaces left were united by means of catgut sutures, while some blood-vessels were tied separately. This healthy part was an inch and a half long and a third of an inch thick; the left tube was undisturbed. Menstruation returned after the operation, and ceased on August 22, 1891; on April 7th pregnancy was progressing favorably, and she was safely delivered of a living child.

Pozzi, in a paper read last spring, strongly favors resection of the ovaries and states that he had good results with the operation.

Martin has done 27 operations in which he made a resection of one ovary or multiple puncture of hydropic or hæmorrhagic Graafian follicles, after the other ovary had been entirely removed. One died; in two the remaining portion of the ovary became diseased and necessitated another operation; of the remaining 24 eight became pregnant.

To these conservative operations Martin adds that of eneucleation of myomata. He first performed the operation in 1879.

Since then his experience has convinced him that myomata should be treated by abdominal section and enucleation in young persons if the tumor is not much larger than a fist, and consist of one or but few sharply-defined nodules. Recurrence cannot always be excluded—that is, that minute nodules latent at the time of operation shall not later be roused into activity. This has occurred four times in 115 cases, but considering the number of nodules found in a uterus and the frequency of myomata, this is not a high percentage. Besides, the same thing is known to happen both after the menopause and after castration. Finally, enucleation preserves the possibility of conception, and the preservation of the sexual faculties is of inestimable value. He reports two cases where conception occurred and labor was normal.

From this review of the opinions of experts I think we are justified in making the following statements:

1st. Women are better mentally and physically for the maintenance of menstruation and ovulation up to the period of Nature's menopause (Polk).

2nd. Resection of the Fallopian tube when it does not contain pus is a practical operation.

3rd. When the tube is so diseased as to demand removal, the ovary being healthy, the tube should be removed and the ovary left.

4th. Cysts of the ovary do not demand its removal in all cases, good results having been reported from resection.

5th. Adhesions do not demand the removal of the tubes and ovaries, unless they are so dense that in breaking them the appendages are seriously injured.

6th. In all cases of chronic disease of the tubes, the cavity of the uterus should be curetted and packed with gauze.

7th. Enucleation of fibroid tumors, leaving the ovaries, is better than to remove the ovaries and leave the fibroids.

8th. Conservative operations upon the appendages, instead of rendering the patients hopelessly barren, have cured a considerable number of cases of sterility.

Pozzi neatly put the whole tning in a single sentence when he wrote: "We have reached a point where the fruitfulness of patients is not so readily sacrificed and where we attempt to cure rather than extirpate."

613 Park Avenue.

Society Reports.

MEDICAL SOCIETY OF THE UNIVERSITY OF MARYLAND.

At the preliminary meeting of the society, held at the University of Maryland in November, the following officers were elected: Dr. J. J. Chisolm, President; Dr. C. W. Mitchell, Vice-President; Dr. W. B. Canfield, Secretary; Drs. J. E. Michael, J. M. Hundley and W. B. Platt, Executive Committee.

The Stated Meeting, held December 5th, 1893, was called to order at 8.30 P.M. by Dr. J. J. Chisolm in the chair; the minutes of the last meeting were read and adopted.

Dr. Walter B. Platt showed a case of "Stunted Development or Congenital Amputation of the Hand; also a Case of Acquired Club-Foot."

Remarks were made on these cases by Drs. Randolph Winslow and F. T. Miles.

Dr. Randolph Winslow showed "A Case of Gastrostomy" in a child of three to four years of age who had swallowed caustic lye, causing extreme dysphagia, necessitating gastrostomy. The child was fed through the opening before the society. He also showed a case of head injury from the fall of an iron bucket which had caused a depressed fracture. He had removed several small pieces of bone over the region of the leg centre. This paper was discussed by Dr. F. T. Miles.

Dr. Frank Martin then read a paper entitled "Sudden Death From Uræmic Convulsions, Following a Median Perineal Section for Stone in the Bladder." This was discussed by Drs. J. J. Chisolm, L. M. Tiffany, F. T. Miles and R. Winslow.

Dr. R. Winslow also showed "A Case of Pus in the Chest Following Grippe." He had made an incision anteriorly and posteriorly and removed a portion of the rib when an enormous amount of pus had escaped and recovery was rapid.

Remarks on this case were made by Drs. I. E. Atkinson, C. W. Mitchell, J. E. Michael and A. H. Mann.

Dr. A. H. Mann then read a paper on "A Case of Emphysematous Gangrene of the Hand, Due to the Streptococcus Pyogenes, and the Bacillus Aerogenes Capsulatus. Recovery without Amputation."

STATED MEETING HELD JAN. 2D, 1894.

The meeting was called to order at 8.30 P. M. by the President, Dr. J. J. Chisolm, in the chair, and Dr. J. J. Carroll, Secretary, pro tem.

Dr. Randolph Winslow showed a case of "Resection of the Hip." A boy 15 years old had been treated for suppurative inflammation of the left hip joint. He cut off the femur below the lesser trochanter and the wound healed with drainage. The boy walked with a crutch and a cane. This was discussed by Dr. Chisolm.

Dr. F. T. Miles showed a case of "Progressive Muscular Atrophy." This disease began in the lower extremities ten or twelve years before. The muscles of the entire body were atrophied except those of the neck. The hand had not the claw position. Strong inspiration was nearly impossible, the effort being accompanied by marked elevation of the shoulders. He walked by locking the knees. He was also unable to rise from the kneeling position.

This case was discussed by Drs. Canfield and R. Winslow.

Dr. I. E. Atkinson then spoke of the "Therapeutic Value of Cold Water Sponging in Typhoid Fever." Sponging was not a rival of bathing, but a good substitute when there are objections on the part of patient or family or when it caused undue excitement and violent muscular resistance.

One case was a young lady whose symptoms were mild at first but sufficiently developed to permit of a diagnosis. The temperature in the evening was only about one degree above normal. Suddenly it rose to 104° or 105°. Bathing was commenced, when patient resisted violently, going so far as to jump out of the tub. The temperature remained high, pulse rapid and weakened; insomnia was so great that sleep had to be induced by chloroform. Symptoms were so increased in gravity that with Dr.

Chew as consultant it was decided to substitute sponging. This was continued from 11 P. M. to 7 A. M. the next day, and temperature fell to normal on the 16th day of the disease. On the 24th day a relapse occurred and sponging was again used and case got well. A second case of typhoid fever was mild and remained so for 8 or 10 days, when suddenly the temperatrue went up very high and bathing was used on the 14th day. In the evening of the 15th day it was 104⅘° and once with this temperature the patient was put in the bath and came out with a temperature of 105°. Finally bathing was abandoned and sponging was used and the back was also rubbed with lumps of ice and the temperature became normal and patient recovered. A third case was also reported with similar results.

These cases were discussed by Drs. S. C. Chew, J. J. Chisolm, F. T. Miles, J. G. Jay and J. T. Smith.

Dr. J. M. Hundley then reported "Several Cases Illustrating the Influence of Constipation on Pelvic Pains." In which he showed from the observation of these cases that the salphate of magnesia alleviated these pains of diseases of the pelvic organs. A cure was not claimed, but the purging did good.

Dr. I. E. Atkinson thought that it was very important to keep the bowels open in such cases.

Dr. Canfield thought that it was more than the mere mechanical irritation of the feces that caused the pains; it was also the absorption through the rectum of fecal poison. He had noticed in the examination of the urine for albumen that the ring of indican which so often appeared above the junction of the urine and acid, gave a hint to the treatment of constipation. When the ring was very pronounced, it pointed to constipation and often in those cases the sulphate of magnesia was not sufficiently active and then he advised aloes, podophyllin or some such powerful purgative.

Dr. L. M. Tiffany then showed some Specimens of Gall Stones. He reported seven cases with their respective symptoms, the kind of operations performed and the results of each. After opening the gall bladder the wound was drained with gauze and allowed to heal by granulation. This paper was discussed by Drs. F. T. Miles, T. W. Clark and I. E. Atkinson.

STATED MEETING HELD FEB. 5TH, 1894.

The meeting was called to order by Dr. C. W. Michell in the chair and Dr. J. J. Carroll, Secretary pro tem.

Dr. J. J. Carroll read a paper entitled "Two Cases of Fracture of the Vertebræ" (see page 425).

Dr. J. E. Michael reported three cases of fractured vertebræ which fell under his observation.

Dr. J. Holmes Smith made an "Exhibition of Specimens," which consisted of a curious arrangement of the splenic veins, specimen of open ductus arteriosus.

Dr. J. E. Michael spoke in the support of the theory that when the distribution of the blood-vessels was such that more blood was carried to one side of the body, that side will be the one to be used by preference; that left handedness depended either upon transposed viscera or upon the abnormal development of the arteries of the left side arising from the aorta.

Dr. C. W. Mitchell spoke of the difficulty and importance of making a differential diagnosis between aneurism of the upper part of the thorax and the unusual pressure of the arteria thyroidea ima.

Dr. Michael spoke of a case of "Galactorrhœa" in which there were measured four gallons in four weeks, not to speak of the amount of leakage and the amount which fed a well-nourished baby 8 weeks old. Milk was also pumped from the breast to keep the woman comfortable, and allowed to remain in a cup for his inspection. Constantly an eighth of an inch of cream would be found on each cup of milk. Remarks were also made by Drs. J. W. Funk and K. B Batchelor.

Dr. J. T. Smith spoke of a "Case of Phthisis," in which the diagnosis was made by the usual signs and symptoms. At one time the symptoms quieted down and no bacilli could be found in the sputa for ten days or two weeks, when again the symptoms became more decided and conspicuous, as before. Another case was mentioned in which the diagnosis of phthisis was made in spite of the negative results of microscopical examination. A post-mortem confirmed the diagnosis. He thought these two cases illustrated the possibility of making a correct diagnosis of phthisis without the appearance of bacilli in the sputa.

Dr. N. E. Iglehart referred to the treatment of phthisis by reducing the temperature with the coal-tar products, especially phenacetin.

Dr. Mitchell, in referring to Dr. Smith's cases, said that the results of this theory could not be conclusive unless the repeated microscopical examinations of the sputum showed a diminution of the number of bacilli, together with an amelioration of the symptoms.

Dr. K. B. Batchelor spoke of the recent attempts by reputable physicians to reduce temperature in typhoid fever by guaiacol. He thought it might also be tried in the treatment of tuberculosis.

THE TREATMENT OF CANCER OF THE STOMACH.

Dr. Brissaud says that it has been known for a long time that solutions of chloride of sodium possess curative properties in epitheliomata of the mouth, and certain chancroids of the nose. On the ground of these observations the author has employed this treatment in cases of cancer of the stomach. Owing to the limited solubility of the chloride of potassium and its comparative poisonous character the sodium salt was selected which is less toxic and can be injected without risk in quite large doses. The chloride of sodium dissolves in three parts of water, while the potassium requires twenty parts of water for solution. As regards the doses 8-16 grammes were given daily. As the results of this treatment the pains were relieved, and some of the gastric symptoms disappeared, sometimes so permanently, that it seemed almost as if a cure had been effected.—*Int. Jour. of Surgery.*

A hasty count through the new Baltimore city directory shows a list of 925 physicians, of whom 46 are homœopathic, 17 colored, 32 women; five of the women are homœopathic, and one colored women belongs also to that school.

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BALTIMORE, MARCH 24, 1894.

Editorial.

THE PHYSICAL PECULIARITIES OF THE ESQUIMAUX.

The influence of climate and social life upon the physical condition of a race is illustrated very clearly by the Esquimaux.

Dr. F. A. Cook, a clever young physician who accompanied the first Peary Expedition to Greenland, has recently delivered an address before the New York Obstetrical Society (*New York Journal of Gynæcology and Obstetrics*, March 1, 1894), in which the habits and characteristics of these people from a medical standpoint are described in a most entertaining manner.

The Esquimaux live in a region of eternal ice and snow, hemmed in by glaciers, and cut off from other portions of the world. Their isolated position has developed habits and customs peculiar to their race. They live on an absolute meat diet, two-thirds of which is raw and frozen, and one-third is cooked to extract the blood, which is their only drink, except melted ice or snow. They use no salt or condiments of any kind. Owing to the scarcity of water, they do not bathe during their whole lives.

The average male is 5 feet $1\frac{1}{2}$ inches tall, and weighs 135 pounds. The average woman is 4 feet 2 inches in height and weighs 118 pounds. Both men and women wear their hair long to protect the face. They are rounded with subcutaneous fat, which is a protection from cold. Girls are betrothed soon after birth and marry at the age of 12 to 19 years, but do not menstruate until the age of 19 or 20, yet pregnancy comes often before menstruation has occurred. Pregnancy is the only permanent bond of union. The sterile girl wanders from man to man until her sterility disappears.

During later life the woman is put in a house all alone and given frozen meat; when her child cries, assistance goes to her; if the cry is not heard the house will not be entered. The woman is allowed to die.

For the first two years the child wears no clothing but is carried on its mother's back under her clothing. The mother nurses her child from four to six years, or usually until she has another, which is on the average about once in five years. When the mother dies before the child is three years old the child is killed. If the father dies before the child is three years old the child is killed so that the mother can marry again.

In times of famine, childless women and old women are allowed to starve, and after death their bodies are used for

food. They have no rules in regard to number of marriages. A man may have three or four wives, and a women may have several husbands.

During the long Arctic night the secretions are diminished, menstruation ceases, and all sexual desire is suppressed in both sexes. They go into a state of semi-hibernation, from which they emerge with the return of the sun, in a state of great muscular prostration.

With the return of day their courtship is renewed with intense activity, and several weeks are given up to sexual gratification. Impregnation usually occurs at this time, with resulting parturition at the approach of the long winter night.

In the case of sterility the husband not infrequently loans his wife for a period of one child to another individual. Dr. Cook recites an instance in which the exchange resulted in a cure of the sterility.

He was unable to explain why lactation continued a period of three or four years, and especially during the Arctic night when semi-hibernation was the rule.

The diseases of these people are usually of a simple and mild character. Rheumatism is their chief complaint. La grippe in a mild form has found its way into their region. In Southern Greenland and Labrador the Esquimaux have made the acquaintance of alcohol, tobacco, tea and coffee, and have learned the vices of more civilized people. Consumption and other diseases contracted by vice and intemperance have destroyed thousands.

The Northern Esquimaux, with his crude surroundings and rough contact with nature, seems to have but few vices and few virtues; where civilization has touched him he has so far contracted the diseases and vicious practices and habits of the white race, without experiencing any of the higher influences. He has actually degenerated in morals and in physique.

GUAIACOL AS AN ANTIPYRETIC.

A new use for an old drug is always better than the introduction of a new therapeutical agent. Guaiacol is an old remedy, which is now being employed externally as an antipyretic. It has been used in typhoid fever, and the recorded results are very rosy. In a case of typhoid fever, twenty to thirty drops are painted over the abdomen and gently rubbed in with the hand for five minutes, when the temperature will drop from four to eight degrees. While the fall is not as sudden as after a cold bath, it is more permanent and the rise is much slower. The strong odor of the drug is a great objection, but it may be disguised by other less ill-smelling substances. It is supposed to act through the skin, on the heat centres as an antithermic and it is not as depressing as antipyrin or phenacetin. Guaiacol used in this way is a simple remedy and its manner of application is so easy that its use should be advocated in suitable cases.

Reviews, Books and Pamphlets

A Practical Treatise on Medical Diagnosis, for Students and Physicians. By JOHN H. MUSSER, M. D., Assistant Professor of Clinical Medicine in the

University of Pennsylvania, Philadelphia; President of the Pathological Society of Philadelphia, etc., etc. Octavo, 873 pages, 162 engravings and 2 colored plates. Cloth, $5.00; leather, $6.00. Philadelphia: Lea Brothers & Co., 1894.

The first thing that strikes one in this work of Dr. Musser's is its enormous comprehensiveness, and this is due to the extreme carefulness and thoroughness with which every means of finding out the disease has been exhausted. Unlike most books on this subject, the subjective symptoms here receive more prominence and are shown to be of great value in arriving at a diagnosis. It would be almost impossible to take up part by part a book of nearly nine hundred pages, but one thing is prominent and that is the important role that bacteriological examination plays in reaching a diagnosis. The first two hundred pages are taken up with general diagnosis, while the heart, lungs, nervous system and liver are treated in about a hundred pages each. This is supposed to be a book for the student, but it is for the advanced student and is certainly not intended for that hackneyed individual, the "busy practitioner." It will, however, be of great service to the reading physician who can take a little time to study groups of cases as he meets with them in general practice. On the whole, the book, while in some cases a little tedious in its details, is a very valuable help and seems to have omitted no point. A good index completes the whole.

An American Text-Book of Gyuœcology, Medical and Surgical. For Practitioners and Students. Edited by J. M. Baldy, M. D. Illustrated. Philadelphia: W. B. Saunders, 1894.

This work, edited by Dr. J. M. Baldy, is the joint contribution of a number of well-known specialists in gynæcology. The names of these contributors are a sufficient guarantee of the value of the work. The volume aims to be modern in its teaching and systematic and practical in its presentation of the subject-matter.

It covers the wide range of gynæcological subjects usually presented in textbooks upon this branch of special work. These subjects have been presented clearly and concisely, and in a form to assist the reader in their intelligent understanding. Irrelevant and cumbersome matter has been eliminated from the text. The work presents the most recent advances in gynæcology, and at the same time is conservative in its treatment of questions about which recent opinions have been formed.

Its recommendations are reliable and the views presented bear the evidence of having been reached by experience and reflection.

The volume is profusely and handsomely illustrated.

The Modern Climatic Treatment of Invalids with Pulmonary Consumption in Southern California. By P. C. Remondino, M. D. Geo. S. Davis, Detroit, Mich. 25 cts.

This little book is written by one who evidently is well acquainted with the country which he describes. The author is not only a physician who understands the needs of the invalids and others who may be sojourning in

Southern California, but he is a practical man and has given much good advice in regard to those important details which even the very best guide books so often omit. He is naturally a little biased in favor of his own region, but he has attempted to be very fair and warns the traveler against expecting too much. The book is well worth a perusal by those interested.

Longevity, with a list of persons known to have lived one hundred years or more. By ARCHER ATKINSON, M. D., Baltimore. Reprinted from the *Virginia Medical Monthly*. Price 25 cts.

This is a paper containing a list of some 250 names of persons who have reached 100 years; some of them have gone many years beyond that period. It is a subject to which the writer has given much time and attention and in this pamphlet are the fruits of his study in that line. It should be in the hands of every medical man, of every student of natural history and of biology.

Enterorrhaphy; Its history, technique and present status. By N. SENN, M. D., Ph. D., LL. D., etc. Reprinted from the *Journal of the American Medical Association.*

Critique of Macroscopic Examination of Specimens Removed in Thirty-two Consecutive Laparotomies. (With one Death). By F. BYRON ROBINSON, B. S., M. D., Chicago. Reprinted from the *Journal of the American Medical Association.*

The Johns Hopkins Hospital Reports. Report in Gynæcology. By HOWARD A. KELLY, M. D., Professor of Gynæcology in the Johns Hopkins University and Gynæcologist to the Johns Hopkins Hospital. This report, containing 430 pages, large octavo, and 63 plates and figures, is now ready. It includes many papers of interest and importance to gynæcologists. Price $3.00. The Johns Hopkins Press, Baltimore.

Tait's Perineal Flap Operation. By F. BYRON ROBINSON, B. S., M. D., etc., Chicago. Reprinted from the *Chicago Medical Recorder.*

An Anatomist's Anomaly Blank; designed for the use of dissectors in recording any noteworthy anomaly that may be found. By Dr. A. HEWSON, Philadelphia.

The sheet has proper spaces for the student's name, the principle normal physical characteristics of the subject, and for anomalies of each of the principal organs or classes of tissues, in proper order and sequence. The proper recording of the anatomical peculiarities occurring in the thousands of dissections made in the country would eventually result in interesting and valuable scientific lessons. Philadelphia: P. Blakiston Sons & Co., 1894. Free of charge to anatomists.

Medical Progress.

HINTS CONCERNING ABSCESS.

Never try fluctuation *across* a limb, always *along* it.

Never forget that:—

1. Abscesses near a large joint often communicate with the joint.

2. Abscesses near a large artery sometimes communicate with the artery.

3. Abdominal wall abscesses sometimes communicate with the gut or solid viscera.

Never forget that *early* openings are imperative in abscesses situated:—

1. In the neighborhood of joints.
2. In the abdominal wall.
3. In the neck, under the deep fascia.
4. In the palm of the hand.
5. Beneath periosteum.
6. About the rectum, prostate, and urethra.

To wait for abscesses to "point" or to "burst" in these situations is culpable as well as cowardly.

Remember the frequency with which hæmatomata and traumatic aneurisms have been mistaken for abscesses, and incised with untoward results.

Do not open an abscess anywhere near a large artery without first using a stethoscope, and then only by Hilton's method (*i. e.*, scalpel, director, and dressing forceps).

Never under any circumstances use for *exploratory* puncture "that surgical abomination—a grooved needle"—for it will allow contamination of all the tissues through which it brings the fluids (Thornton).

Never plunge in opening abscesses; never squeeze the sac after doing so.

Do not forget that your incision should radiate:

1. In abscesses pointing near the nipple.
2. In abscesses near the anus.
3. In scarifying the chemosis of the cornea.

And that your incision should be longitudinal:—

1. In the hand.
2. In the urethra.
3. On the vertex.

Do not forget that incisions for abscesses in the neck and face should run parallel with the wrinkles and folds.

Do not be afraid of hurting the lacteal tubes in mammary abscess. More harm is done to the gland by the enlargement of the walls of the abscess than by a free incision.

Never make a palmar incision except in the middle of the lower third and in the axial line of the fingers or at the sides of the palm.

Do not forget, in opening a deep abscess in the lumbar region without the projection of the abscess, to cut down opposite a transverse process, not between them, for fear of wounding a lumbar artery.—*Ex.*

MORTALITY OF TUBERCULOSIS.

Dr. Lagneau said that his investigations into the relationship existing between occupations and the development of tuberculosis showed that the greatest number of deaths from phthisis occurred in workers exposed to irritating substances in the respired air. In Switzerland 10 out of 100 stone-cutters die from phthisis. In England, of 1,000 deaths occurring in these workers, 340 were from phthisis. Tuberculosis makes cruel onslaught likewise in those individuals who habitually occupy a bent posture at their occupations, and in those who live sedentary and intellectual lives. Of 1,000 deaths in Italy among students and seminarians, 450 died of phthisis—that is, nearly one-half. In England, of a similar number of deaths in printers, 430 died of phthisis.

On the other hand, statistics show that it is quite exceptional for this disease to

be the cause of death of those who live in the open air. In Switzerland, of 1,000 deaths occurring in out-door laborers and farmers, not more than one or two die from phthisis. A similar number of deaths in Italy among shepherds and farmers shows only from fourty-four to fifty-five deaths.

In France the sanitary statistics gathered from six hundred and sixty-two towns show that the more the population is conglomerated, so in proportion are the inhabitants gravely affected with tuberculosis.—*Medical Record.*

THE FATE OF UNVACCINATED CHILDREN AT LEICESTER.

The price of defiance to vaccination and vaccination laws is being paid heavily in Leicester. But for the peculiar mental constitution of the sanitary authorities of that town, some sense of responsibility for the deaths which have occurred would be unpleasantly present; for the blows of simple truth fall heavily on them. The facts are appalling in their simplicity. True, they relate to children to a larger extent than adults; but we will not allow ourselves to believe that the cry against the authorities is altogether unheeded. The situation is fast ceasing to be one in which the Local Government Board can connive and become a party by acquiescence. With such mortality from any other cause the facts would be investigated by a coroner, and questions of manslaughter would obviously arise. Let us look dispassionately at the facts we published last week. Of 281 cases of small-pox 126 were unvaccinated. We concede, of course, that this leaves 155 who, though vaccinated once, had taken small-pox; but what are the vital facts of the case? Of 126 unvaccinated patients no less than 83 were under 10 years of age, and in 9 of these the disease was fatal, whereas there was no instance of small-pox occurring in a vaccinated child under 10 years of age; and of the 155 cases of the disease occurring in persons, vaccinated indeed, but not revaccinated, there were no deaths. If there is any logic which will acquit the sanitary authorities of the responsibility of these 83 cases under 10, and of the 9 deaths among them, we should be glad to have it pointed out. We do not say anything of disfigurement or of other possible sad consequences to those who have survived. We shall perhaps get a little further light on this subject. Meantime we urge on the attention of the Government the cruel results which a neglect of the vaccination laws is causing. If the President of the Local Government Board does not feel equal to asserting his authority, it is not too much to hope that the Home Secretary will think it a case justifying his interference. Death and disease on such a scale from lead-poisoning or phosphorus would certainly not fail to find a remedy; and in this case he has a remedy at hand and one that is absolutely reliable.—*London Lancet.*

TUBERCULOSIS OF THE BLADDER—DRAINAGE AND REST.

Dr. Hunter McGuire says in the *Virginia Medical Monthly* (March, 1894):

Four years ago, I found one day in my hospital a young man, who gave me the following history: He was twenty-two years old; had had occasional symptoms of trouble with his bladder for about

two years; had never had gonorrhœa or syphilis. His mother, aunt, and two sisters had died with consumption.

Two or three months ago, during the act of passing water, he was suddenly seized with pain in the end of his penis, and found the last few drops of urine contained blood. Frequency of micturition was the next symptom, and this last became gradually so urgent, that he sat for hours on a chamber-pot, discharging every few minutes about a teaspoonful of urine. He was in this position when I first saw him, the vessel being on the floor, and his thighs flexed on his body until his chin rested on his knees. He said that no other position gave him as much comfort during "his spell." The symptoms in the end of the penis, the occasional appearance of blood, and frequency of making water, were like those of stone. Unless he was under the influence of morphine, the pain kept him awake for hours at night, and he was compelled to get up every few minutes and make water. I found he had periods of rest just as patients do in cases of stone in the bladder. He went sometimes a week or more without pain or very frequent micturition; sometimes the respite lasted only a day or two. During the intervals of his attacks, exercise did not hurt him; he could ride on horseback, jump out of his carriage, without bringing on an exacerbation of his symptoms. I found, during an interval of rest, that his bladder had diminished in size, and the evacuations at his best were more frequent than natural. The urine was odorless, contained some pus, and was slightly acid. In the epididymis of the right side a slight swelling was discovered, which, when opened, discharged tubercular-looking pus. In examining the prostate through the rectum, I could feel a number of hard, shot-like bodies. This man had the history and symptoms of tuberculosis of the bladder.

It occurred to me that if I could put this man's bladder at rest, I would give him at least great temporary relief. I made a supra-pubic opening, as you would do for stone, introduced a drainage tube, and the effect for good was almost immediate. The urine was drained off as fast as it was poured into the bladder, and tenesmus ceased. In four or five months the man was well, and has remained so ever since, it being now nearly four years since the operation.

I have had four other cases like the one described, in which I have operated and drained. In two of them death soon followed the operation. In both of these the change in the tubercular bladder was extreme. In both the bladder was contracted and the mucous membrane almost entirely destroyed. One died from exhaustion following the operation; the other in a few weeks from general tuberculosis. In both the suffering was lessened by the drainage. The other two of the last four cases got well—one after a drainage of ten or twelve months; the other still keeps the artificial tract open, and although relieved of all bad symptoms, declines to let it close up.

I mention these cases, and the success that I have had in drainage and rest of the bladder in tuberculosis of that organ, to induce others to try the process.

SUDDEN DEATHS IN CONFINEMENT CASES.

A writer in the *Times and Register* says that not long since a case came to his

notice in which a woman was having an enormous *post-partum* hæmorrhage. With the first gush of bright red arterial blood through the vagina, the medical attendant became quite rattled, and, of course, at once attacked the uterus, stuffing its cavity firmly with antiseptic gauze, and then commenced to inject beef extract up the rectum, that she might make blood for what she was losing. But seeing that his patient was fast sinking, and that he was powerless to control the flow, a consultant was sent for. On his arrival he at once removed all the uterine packing, caught the neck of the uterus and pulled it into the vagina, when there, by the aid of a candle, he saw an enormous laceration up its inner wall, which tore the left uterine artery in two. In an instant the bleeding vessel was in the safe grip of a hemostatic forceps; a life had been saved.

The writer says he is acquainted with another somewhat similar case. The woman had a normal labor, but a free hæmorrhage promptly followed. Now the medical attendant at once ordered ergot, carried a lump of ice up the uterus, then packed its cavity with a sponge soaked in vinegar, kneaded the surface, and poured pitcher after pitcher of ice water in, but all to no effect, as the bleeding continued.

As the woman was becoming desperately weak, they hurried for a consultant. On his arrival he inquired as to the color of the blood. They told him that it was a tarry black. He in a moment allayed their fears by telling them that it would not be a mortal hæmorrhage, and that he believed he could easily arrest it. We can imagine the chagrin of the family physician as the consultant, with his speculum, showed him that there was not a drop coming from the uterus, with all its tamponage removed, but that it entirely escaped from a large rent in a vaginal varix, which, with a pin and a piece of thread, he transfixed and secured in a moment.

Vinay, in the *Tocological Archives* for April, discusses at considerable length, in a highly valuable contribution, the many and complex factors which enter into the etiology of sudden deaths in labor. Many of them, he says, may be prevented, while not a few are hopelessly mortal. In any event, in all cases of obstetrics the attendant must be always on his guard for the signals of danger, so that, appreciating its significance, he may anticipate and perhaps wholly obviate it.—*National Med. Review.*

A CASE OF PUERPERAL BONE SOFTENING CURED BY CASTRATION.

Harajewicz (*Wiener medizinische Presse* 1893, No. 27) reports an interesting case of successful removal of the ovaries for the cure of puerperal bone softening. The patient had had ten children, and was in her eleventh pregnancy when she began to have severe pains in the loins, back and hips. Her twelfth pregnancy was attended by more severe and continuous suffering; all the bones of the body except the face became acutely tender, and coughing caused intense pain. No visceral disease could be found; the urine was normal. The deformity of the pelvis and skeleton generally was now marked; there was no ovarian tenderness, and no uterine disease. The operation was performed under strict antiseptic precautions; both ovaries were removed and found to be normal. Complete and

permanent relief from pain at once ensued, and after three months the patient left for her home. The bones were hardened, but crooked. Should this condition develop during pregnancy, it is probably best to empty the uterus; and, if it continue, castration may follow, or a Cæsarean section may be made at once, the ovaries being removed at the same time.—*Amer. Jour. Med. Science.*

Medical Items.

The Sultan of Turkey has issued a proclamation allowing women to practise medicine in his dominions.

The Board of Health of the State of Washington requires physicians to report cases of pulmonary tuberculosis in that State.

The Virginia Legislature had a bill pending to cause the appointment of a proper number of women physicians to each hospital for the insane. The bill was lost.

The Baltimore University School of Medicine held its annual commencement last Wednesday night, and conferred diplomas on a number of candidates.

A number of trained nurses met at the Garrett Free Hospital for Children, and organized an association for the purpose of establishing in some convenient part of the city a nurses' directory, where skilled nurses may be had night or day. Only nurses having diplomas or certificates from well-established hospitals will be allowed to register.

The Faculty of the Baltimore Medical College will begin in a few days the erection of a large new building in place of the present Maryland General Hospital and Maryland Lying-in Hospital. The building will be four stories high, and will contain all the modern improvements, giving accommodation to 150 patients.

Negotiations are said to be in progress between Dr. J.S. Billings, on behalf of the Surgeon-General's office, and the family of the late Professor August Hirsch, of Berlin, for the purchase of the library left by the latter, which consists of about 10,000 volumes. The Germans are trying to raise money to prevent this valuable library from leaving their country.

The Forty-fifth Annual Session of the Medical Association of Georgia will meet in Atlanta, Ga., on April 18, 19, 20. The officers are: President, W. H. Elliott, M. D., of Savannah, Ga.; Vice-Presidents, G. T. Miller, M. D., of Americus, H. McHatton, M. D., of Macon; Treasurer, E. C. Goodrich, M. D., of Augusta; Secretary, Dan H. Howell, M. D., Atlanta, Ga.

The number of deaths from typhoid fever in Paris in 1893 was only 633, as against 1,035 in 1886, and 2,120 in 1880. In 1869 the death-rate from this disease was 53.4 per 100,000, in 1882 it was 147, and in 1893 only 25.7. This diminution is attributed to the increased supply of pure water and the diminished consumption of water from the Seine. At present the supply of water is at the rate of about thirty gallons per day to each inhabitant.—*Medical Rec.*

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Original Articles.

ABSTRACT OF TWO ARTICLES TREATING OF PROGRESS IN MIDWIFERY.*

BY HUNTER ROBB, M. D.,

Associate in Gynæcology, Johns Hopkins University, Baltimore.

In Nos. 1 and 2 of the *Münchener Medicinische Wochenschrift*, of January, 1894, appears an article entitled "Progress in Midwifery," by Dr. Döderlein, of Leipzic. In the *Berliner Klinische Wochenschrift*, of January, 1894, Professor Veit publishes an article on "The Principles of Asepsis in Obstetrics." As the two treat really of the same subject, I thought it best to take them up together.

*Read before the Johns Hopkins Hospital Journal Club, February 26th, 1894.

Döderlein begins with a definition, "Birth is a physiological process of life in which where it is possible all artificial assistance should be avoided." This apparent truism, he says, has been much disputed, not only at the beginning of the century, but even just lately; because, where the labors were for the most part conducted by midwives, obstetricians met with more pathological than normal cases, so that they were unable to appreciate the boundaries which separated the physiological from the pathological process.

Von Jörg, who declared birth to be "a normal act of evolution, both for the mother and the child," saw the necessity for lying-in hospitals, for in them only could proper observations of normal physiological labors be made. Having become convinced that not only could na-

ture bring about many births which had before been finished by means of extraneous help, but that certain incidental processes were necessary in order that certain changes caused by pregnancy might be the better compensated for after delivery, he laid down as a cardinal rule that "no operative assistance should be given unless danger threatens the mother and the child."

In spite of the prediction of Jörg and Boer that obstetrical operations would become much rarer, the statistics of Hegar for Bavaria from the years 1870 to 1887 show that the frequency of obstetrical operations had risen from four to seven per cent., and that with a higher rate of operations, the death-rate also was higher. Döderlein therefore agrees with this statistician that the labor should be allowed to take place naturally whenever this is possible, for that in these cases one can always be assured of a better prognosis for the puerperal period.

The increase in the frequency of operations may be ascribed to two factors: (1) the condition which necessitates an operation is recognized earlier and (2) the civilized woman bears children with greater difficulty than the savage. As a matter of fact, the children of savages are smaller and the crossing of races tends to produce larger children.

Besides this disproportion between the measurements of the pelvis and those of the fœtus in the civilized woman we must take into account the strength of the labor pains.

The statistics are much influenced by those which are taken from regions where rickets is of frequent occurrence. It is worthy of note that where fifty per cent. of the men could not pass for soldiers, the number of women unfit to bear children was increased. Rickets is the most frequent cause of a narrow pelvis and this defect is indirectly the cause of (1) faulty positions, (2) prolapsus of the cord or extremities, (3) rupture of the uterus.

The forces by which labor is brought about, namely, the uterine contractions and the power of the abdominal muscles and diaphragm, are as a rule more feeble in the woman of higher civilization.

Döderlein arrives at two conclusions, the second of which modifies to some extent the first: (1) the act of birth is a normal physiological procedure for the mother and child, and (2) the act of giving birth to a child in our present state of civilization is exhausting to the mother, and abnormalities in either mother or child sometimes exist which cannot be overcome by the unaided strength of the mother.

This, then, is the duty of the obstetrician: (1) abnormalities or difficulties must be recognized early so that we may by slight manipulations give help before severe complications are produced. In order to do this a right diagnosis is absolutely necessary. The presentation must be recognized and it should have been discovered beforehand whether the viæ naturales are of sufficient size to permit the fœtus to be born. (2) In normal cases the principal danger is from puerperal fever. Bacteriology has taught us the cause of puerperal fever, and since women who have had a normal birth should have a perfectly healthy puerperium, it is for us to prevent the ingress of septic material into the system of the parturient woman.

Puerperal fever is due to the infection of wounds by pathogenic organisms. We have, then, two factors: (1) wounds and (2) micro-organisms. After birth, even a normal birth, we have wounds, and the portal for infection being opened, it is the second factor which we must combat. Two methods are suggested for attaining this end: (1) the disinfection of the hands and instruments, or in fact of everything which comes in contact with the genitalia from outside; (2) the thorough disinfection of the woman herself. The success of our prophylactic measures after a trial of more than ten years has been disappointing. Puerperal fever still exists, although the number of cases has diminished. In order that the second method may be properly practised we should need an entirely different class of women for midwives. He presupposes a thorough appreciation of the necessity of antiseptic measures by obstetricians.

Döderlein concludes as follows:—Under existing conditions in normal labors, in order to advoid puerperal fever we are not called upon to improve upon nature by disinfecting the viæ naturales through which the child is born, but have only to carry out the old law to leave nature alone and allow her to act. As every examination, unless the hands are absolutely sterile, has certain risks, we must make none that are not absolutely necessary.

Veit points out that whereas the most important surgical operations are generally performed in well-equipped operating rooms, in the most difficult obstetrical operations we have often to combat the inconveniences of the private house, and the consequent danger of breaks in the technique. While we are agreed that under all circumstances we endeavor to avoid carrying in from without pathogenic organisms into the genitals of the woman, the opinions as to the proper methods of procedure are apparently often conflicting.

Ahlfeld, having come to the conclusion that auto-infection plays the chief role in the ætiology of puerperal fever, insists upon the disinfection of the vagina and cervix as an absolute necessity.

Leopold, holding that the chief danger of puerperal fever lies in the examining hand, would forbid any internal examination unless abnormalities exist. On the other hand, he insists upon the most stringent disinfection of the outer genitals.

Veit, after noticing the divergent opinions of men who have exactly the same end in view, endeavors to state the principles most generally accepted at the present time. He treats of them under five heads. (1) The subjective disinfection of the obstetrician can never be too strict. He says that Fürbringer's method is founded on a scientific basis. He condemns any attempts at simplification of such a method, because he fears that they may lead to the neglect of important points.

(2) The disinfection of the patient is divided into (*a*) that of the external genitals, and (*b*) that of the vagina and cervix.

The disinfection of the external genitalia is always useful. Scrubbing for five minutes with brush, soap and water, and then using a sublimate or carbolic

acid solution for several minutes, is not always feasible in private practice. The soap can be well rubbed in with linen or cotton wool and then be gradually washed off, the sublimate or carbolic acid solution being afterwards applied.

Great care must be taken to clean the pubes and the perinæum, especially around the anus, since experiments have shown that the bacterium coli commune is sometimes the cause of puerperal fever. When operative interference is determined upon the disinfection of the external and internal genitalia is necessary and can be done easily and effectually after the anæsthetic has been given. In normal labors it has been much disputed whether the vagina should be disinfected or not. Winter discovered that pathogenic organisms from the vagina can penetrate to the os internum, but holds that their virulence is decreased. Döderlein, Steffeck and Burckhardt showed independently that pathological secretions existed in over forty per cent. of the cases under their charge; although in Döderlein's cases the presence of virulent streptococci was demonstrated by inoculation into animals in only 9.2 per cent.

Contrary to what might have been expected, Döderlein and Burckhardt concluded from these experiments that no attempt should be made to disinfect the vagina, giving as their reasons that not only is this disinfection difficult, but there is danger of carrying the pathogenic organisms still higher up.

The question then of disinfecting the vagina refers only to cases in which a pathological secretion is present, and it must be left open, since we have no means of immediately determining whether a pathological secretion contains virulent pathogenic organisms or not.

Ahlfeld thought he showed that infection was rarer where disinfection of the vagina had been practised; out of one hundred cases in which no disinfection of the vagina was carried out, but in which also no vaginal examination was made, in thirty-nine there was fever. (He reckons all cases in which the temperature went above 38°C.)

In seventeen cases in which the mothers evidently had gonorrhœa, as was proved by the infection of the eyes of the children, only three remained afebrile. In these cases presumably the vagina was disinfected and yet there was infection in 82.3 per cent. So that it seems that in these cases the disinfection helped neither mother nor child; why, therefore, should it do so in other cases in which pathological secretions exist?

Of course these were not the only cases in which gonorrhœa existed, but only those in which it was proved to be virulent. Now only in nine per cent. of Döderlein's cases were the pathological secretions proved to be virulent, and so these are the only ones in which one might have supposed disinfection to be necessary.

Ahlfeld has proved that this disinfection has done no harm. Has he proved that it has done any perceptible good?

When we consider that cases of autoinfection are not generally serious, it seems inadvisable to insist on a disinfection of the vagina. There are also dangers, more especially where this is left to the midwife. We may have bi-chloride poisoning and the pathogenic organisms may be carried into the cervix. Besides, the disinfection cannot be

thorough without anæsthesia. As we have just said, it should be always practised before operations, or when signs of putrefaction exist and the patient is found to be infected at the time that the birth is going on. Here Ahlfeld's statement is important that "in cases where fever comes on during labor it can be reduced by thorough disinfection of the vagina."

(3) The third opinion is much disputed, viz: "that the normal birth should be conducted without a vaginal examination." This only applies to physiological labors which are left to midwives, or in which a physician is only called in to be at hand in case anything should go wrong, and in order that any abnormality may be recognized early. "Out of 1000 cases in the Dresden Lying-in Hospital, 40 per cent. were not examined per vaginam. (I suppose Veit means during labor.) In from 4 to 6 cases out of 10 in his private practice, Veit says he did not examine per vaginam. All did well. Of course if the midwife has already made an examination we need not fear to do so."

Veit continues:

"I think then that an examination per vaginam should only be made where there are indications for it. I do not mean that these indications need necessarily imply anything pathological. Sometimes, for instance, in cases of severe pain we may examine to see whether it might not be advisable to rupture the membranes."

But the ordinary methods of external examination are not always sufficient. It is not always easy to find the head and back through the abdominal walls and more especially one cannot feel the head from in front when it passes into the superior strait. The examination from the posterior wall with the woman on her side is of the greatest importance. The head as it comes down can be felt near the sacrum in the incisura ischiadica on the side to which the back of the head is turned. Then it can be followed along the side of the coccyx and along the perinæum. Thus we can tell whether the head is presenting and watch its progress.

If, however, an examination must be made, the finger should be passed directly into the vagina (the examination should never be made under cover) and should not be allowed to touch the perinæum.

It has been proved that infection has been caused by the bacterium coli commune and this has probably been introduced from around the anus or from the perinæum. Again, all through the labor one hand should be kept sterile, the palpation being done with the other.

(4) The importance of sepsis in obstetrics is nowhere more evident than when it is necessary to treat abnormalities, viz.:—hæmorrhage. As a matter of fact fatal cases of hæmorrhage from atony of the uterus only occur in 1-100 of 1 per cent. of cases. Atony of the uterus is seen in $\frac{1}{4}$ of 1 per cent.

Of course hæmorrhage after the child is born occurs more frequently, but if it is due to the gradual loosening of the placenta it stops as soon as the uterus can contract. But hæmorrhage can also come from lacerations, although these sometimes cease as the uterus contracts.

The occurrence of hæmorrhage does not necessarily mean that we are to put our hands in the uterus and tear off the placenta. It is significant that this man-

ual deliverance of the placenta occurs much more often in outside than in hospital practice. We must determine whether the bleeding is due to the loosening of the placenta and partial atony of the uterus, or the lacerations. In the former case we "rub," in the latter we "sew." In the former case Crédé's method will usually be successful.

When the placenta is adherent, ample time is allowed for thorough disinfection of hands, external genitalia and vagina.

He concludes by saying that of course we have to be taught to make vaginal examinations in order to understand the mechanism of labor, but insists very much on more thorough instruction in external examinations. Any number of students can examine the same woman externally, as it gives her no pain and does not offend her modesty.

Many improvements can probably be made in the technique of obstetrical operations. We do not go blindly about things. We do not follow Crédé literally now and drop a solution of nitrate of silver into the eyes of every newborn child. We look for indications. And for any manipulation upon the woman in labor we must have indications.

Since our efforts are tending to do away with the dependence upon chemical solutions we can say that they aim at bringing about asepsis.

Schroeder has said it is better to let a woman take her chances and be delivered in a gutter than that a hand of doubtful surgical cleanliness should be placed in the vagina.

"We obstetricians, besides making a diagnosis and treating pathological conditions, have this duty, viz.:—to see that no pathogenic organisms are carried into the woman from without. The harmful substances which a woman carries internally in the genital canal she can as a rule more easily overcome without our interference or our assistance."

AMERICAN GRIPPE, OR MYXOID-ŒDEMA.*

BY CARL SEILER, M. D.,

OF PHILADELPHIA.

MR. PRESIDENT: I have been asked to present my observations of American grippe and its after-effects. Of course, the subject is one which is so interesting to all of us, and which is, unfortunately, so mixed in the minds of many, that it will be possible for me, in the short time, to give only a *résumé* of the subject. Therefore I hope that the few remarks that I shall make may be of sufficient interest to the members of the Society to call forth their expression of opinion and relation of clinical observations of much more value than my own.

In 1885 I observed the first case of this peculiar disease. I afterward (in 1887) discussed the subject with Dr. Glasgow, of St. Louis, who, strange to say, had made observations similar to my own; and as there was no disease which had been described which, to our knowledge, came anywhere near the one under discussion, he had called it "It," and so had I. The disease was first described by me in a paper published in April, 1889. Dr. Glasgow reported his observations to the American Laryngological Association in May, 1889, and in June of the same year I read my

*Read before the Philadelphia County Medical Socety, February 28, 1891.

paper before the American Medical Association at its meeting at Newport. You may remember that at that time I referred to the fact that the disease was spreading all over the country, and that I had received letters from Montana, Washington, the Canadas, from the South, and, in short, from all directions, after having made inquiry about the new disease. Geographical situation, elevation, temperature, and atmospheric conditions apparently had nothing to do with its causation; in fact, the disease was everywhere the same in its specific characteristics.

In 1889, in the month of December, the disease broke out in New York City, where it assumed the proportions of a very alarming epidemic, and its existence was recognized as an epidemic general and fatal all over the United States within a very few weeks after its recognition in New York. Unfortunately it was called "la grippe," or the Russian influenza, a disease differing entirely in its clinical character and prominent pathological lesions from the disease erroneously named by the public press. I then published a paper in March, 1890, in which I gave the differential diagnosis between the Russian influenza, or "la grippe," as well as of other diseases mistaken for it, and the American disease. Last March (1893) I published the fourth edition of my book on *Diseases of the Throat*, in which I devoted an entire chapter to the consideration of this disease, under the name of "American grip," or myxoid-œdema, to distinguish it from the "Russian" or European influenza. The distinction is similar to that which we are accustomed to make between measles and German measles, or morbilli and rubella (Rötheln).

The peculiar symptoms of the American grip are: the sudden onset; the rheumatic pains, in all parts of the body, accompanying the sudden onset; an abrupt rise in the temperature, with moist skin; a peculiar tension; no inflammation of mucous membranes. In some cases a deposit of pseudo-membrane occurs upon the tonsils and elsewhere, which, however, is of entirely different character from the pseudo membrane of croup and of diphtheria. There is a peculiar puffiness of the mucous membranes, which shows itself wherever the deposit is most developed. It occurs in the throat, in the larynx and nose, in the bronchial tubes, and in the mucous membrane of the intestinal tract. In its prostration of the vital powers of the body the disease is something like typhoid fever; but with it there is no fever, no exacerbation of high temperature; there is no thirst, no dryness of the skin, and no brown coating of the tongue. In one case the temperature was 105° F. at the beginning, but it went down to normal in twenty-four hours. The pulse was 76 right along, and had none of the characters of a fever pulse. In those cases in which death occurred the temperature was reduced to normal, or even sub normal, and the giving out of the heart was the original cause of death.

In some cases the sub-mucous infiltration is most evident in the vocal bands, and here the consequent closing up of the larynx causes suffocation. The immediate cause of death is usually a small hæmorrhage in the mucous membrane in such cases. Ecchymotic spots are

often observed in the throat, bronchial tubes, and also in the stomach and intestines. Indeed, there may be black vomit, like the black vomit of yellow fever, and the stools may also show the presence of effused blood.

I am now speaking of the symptoms of American grip. I need not refer to the symptoms of Russian grippe, since I could not add anything to the admirable review of them given by my friend, Dr. J. C. Wilson, in his article on "Epidemic Influenza," in Pepper's *System of Medicine*, which you are already familiar with.

In the matter of treatment I found the greatest benefit from a long-discarded drug—which, I must admit, is of no use in any other disease—the benzoate of sodium. In American grip it acts as a specific, precisely as quinine acts in malarial fever. It relieves the pain at once; it brings down the temperature; it relieves the oppression of breathing, and removes the false membrane from the throat. This remedy, with alcohol and rest, constitutes the whole treatment of the disease. In my experience I have found that it is an absolute specific—of course, provided that the diagnosis had been correct. As to other drugs, I would say that all those patent coal-tar remedies are only a cause of death. They act as heart depressors, when the heart is already profoundly depressed by the disease. Antipyrine, antifebrin, and all the other antis are worse than useless. The heart needs to be supported, and they all cause further depression. Quinine is often a cause of insanity and suicide. During the last three years I have made a careful investigation of all published cases, whenever possible, where insanity had been the cause of death in grippe, and I found that quinine in large doses had always been given to the patients. I have observed, in my own cases, that even very small doses of quinine will often cause mental disturbance.

Thus far I have considered only the acute condition. If benzoate of soda is not given, and the patient does not remain in bed, a chronic condition of grippe will be produced. This is a very distressing condition, as I know from personal experience. The symptoms are so different that they cannot be given in detail, and it is difficult to make a diagnosis. There is a flabby, pale, or coated tongue, want of appetite, impaired digestion, irregularity of bowels. With this there is a depression of spirits, want of ambition, and inability to perform any work requiring exertion of mind or body. A little over-exertion will throw the patient back, and it will be days and days before he can regain his former position and begin to gain strength.

The pathology of the chronic cases has been shown to be a slow process of fatty degeneration of all the organs of the body except the kidneys. And, if there has not been pre-existing disease of the kidneys, there will be no albumin in the urine.

The chief symptoms of the chronic form are general neurasthenia, associated with chronic distention of the venuoles, and anæmia of the arterioles throughout the body. This was seen by ophthalmoscopic examination in the eyes, where it produced impaired vision or blindness. Blueness of the skin is due to the same venous congestion, evidently of neurotic origin. Besides the mental depression,

there are hallucinations of peculiar character and irritability of temper. Light has a depressing effect, while darkness causes exaltation. Toward evening the patient usually feels much better than in the early part of the day. I have observed that a patient may go to sleep at ten o'clock and wake up at eleven in a state of mental exaltation. He feels like getting out of bed and walking about his room, or relieves his mind by writing poetry; this is the only thing that will enable him to go to sleep again. I have some very curious specimens of this "grip poetry" in my possession. The irritability of temper I have referred to is beyond the control of the patient, although he is fully aware of it; this is part of a hysterical condition, and under slight exertion, or emotion, a condition of hysterical aphonia may be developed, even in men.

Then, again, the patient is very much disturbed by all kinds of rhythmical noises, especially at the seashore, where the "one, two, three" of the breakers nearly drives him out of his senses. Even if he cannot hear them, he is conscious of annoyance from the rhythmical repetition of the waves, and this will make him extremely nervous, so that he cannot sleep. The rapid succession of the trolley-car bells is also very annoying, and I have had patients who were driven out of the city by these noises.

The treatment of the chronic grip is by alterative tonics. Buchu may be given as a mild diuretic. If there is sleeplessness, bromides are useful. All the coal-tar preparations are bad. Of the narcotics, the best is hyoscine in small doses; as a tonic, strychnine in considerable doses. begining with gr. 1-32 up to gr. 1 16, three or four times a day. A change of climate is advisable, and the best I have found is a moderately high place, where there is plenty of oxygen and an absence of noise. This is necessary to obtain rest for the mind and body. Mineral waters are valuable, and I found at Bedford great advantage from the use of the water, but there is a spring at Swiftwater, near Pocono, which I consider even better.

The wine of coca is especially useful when the patient begins to exercise as a "pick-me up."

Where the patient must keep at his work the coca is a valuable remedy, as in the case of a preacher who has not sufficient strength to go through with his sermon without some such aid.

The Savannah Medical Journal Publishing Company announces a new monthly medical journal to be especially devoted to the interests of the medical profession of the Gulf States.

Governor Pattison, of Pennsylvania, has appointed, under the new law passed in May, 1893, a Medical Examining Board composed of physicians from the regular, homœopathic and the eclectic schools.

The College of Physicians and Surgeons of Richmond, Va., has changed its name to the University College of Medicine. A new charter has been granted giving university features, and departments of Medicine, Dentistry and Pharmacy have been organized with distinctive Faculties. The School can now confer the degrees of M. D., D. D. S. and Ph. G.

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BALTIMORE, MARCH 31, 1894.

Editorial.

STILL PINCHING THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE.

The bill for the support of the Army just reported to the House of Representatives, indicates that its framers have a settled determination to impair the utility of the best Medical Library of the country. When the Committee on Military Affairs first cut down the annual appropriation from $10,000, to $7,000, the saving to the Government was not of appreciable magnitude, but the loss to the Library, and by consequence to the medical profession in general, was serious and regrettable. It has taken years of systematic and intelligent research to perfect the machinery through which all the current medical publications of the world, books and journals, could be received, indexed and made immediately available for the seeker after knowledge.

Physicians from all parts of this broad land come to Washington with the certainty of being able to consult this noble Library, the works which thirty years ago they would have had to cross the sea to find together. And they can find, further, the whole of this vast body of medical literature indexed by subjects so that it becomes at once, as it were, an open book to them. In no other libraries in the world, general or special, is there such an index-catalogue. Its completion is, we trust, assured. But it is a source of regret and humiliation to learn that for the sake of a very small saving to the treasury the continued systematic building up of this valuable library is to be hampered and depressed.

Beginning, as its name imports, as a collection of books for the use of the Medical Corps of the Army, it has long since overpassed its original purpose, and it stands to-day with the best medical libraries of the capitals of Europe. It is the clear duty and interest of the physicians of the United States, either individually or through their medical societies, to urge upon Senators and Congressmen the importance of restoring this modest appropriation to its original amount. As the bill is already in the House of Representatives prompt action in the matter is especially important.

BACTERIOLOGY IN ITS RELATION TO TREATMENT.

That ever-changing department of pathology, bacteriology, is a subject which few understand thoroughly, and the majority of those who know little or nothing about it ask what its place is in regard to practical medicine and what it

has added to our knowledge of the treatment of disease. This is a practical question which Dr. William Hunter (Year-Book of Treatment, 1894) has in part answered.

Although it is the newest branch of medicine, it has influenced to a greater degree our treatment of disease both directly and indirectly than any other part of pathology. By finding the specific cause of many of the infectious diseases, bacteriology at once gives us a clear idea of what infection is and how disease is spread, since we know not only the actual agents that cause infective disease, but the conditions which influence them both within and outside of the body; the way they attack us, and the disturbances they produce. The whole antiseptic treatment of disease is the result of bacteriology. Preventive medicine owes its great advances to that science and added to all this it is through bacteriology that we are beginning to understand how the healthy body protects itself against attacks of disease or recovers after an attack.

In the beginning of the study of bacteriology the form of the various organisms was the principal topic of investigation and their manner of life; that is, their morphology and biology; then their ways of producing disease by the poisons contained in their minute bodies next demanded attention, that is their physiology; and lastly the manner in which the body reacts in the presence of these organisms either during illness, recovery or in a state of immunity. The latter part of the subject, immunity, is leading the way to a practical treatment of disease by methods founded on bacteriology. It would be impossible to cite each disease and its bacteriological history, but the general effect of blood serum as a therapeutical agent, as first announced by Behring and Kitasato, opens a broad field for practical suggestions.

Bacteriology is then not only an exceedingly interesting study, but, more than this, it leads to practical results and in this age of utilitarianism it is necessary to show to some persons of doubting disposition how much good has been and will be obtained from this apparently theoretical branch of medical science.

IS THERE EVER A TIME WHEN PHYSICIANS SHALL CHARGE OTHER PHYSICIANS AND CLERGYMEN?

Two questions come up again and again in the practice of medicine. One is, "Is there ever a time when one physician should charge another?" and the other is, "Should physicians treat free of charge clergymen who are able to pay?" These are difficult questions to answer.

On account of popular prejudice and precedence it may be very pleasant and harmonious for physicians to exchange professional courtesies, but as a matter of fact this is rarely a fair exchange.

It may be laid down as a general rule that physicians in actual practice and the immediate families depending on such physicians ought to receive free treatment; also physicians or their families in straitened or indigent circumstances.

Indeed, this rule may be stretched to a great degree and few right-minded men would object. But there arise so many

cases where physicians have given up practice and are following successfully other occupations, or have independent fortunes and do nothing. It is hard to see why such men should not pay for professional attention to themselves and their families, more especially when there is a difficult operation or a long illness. And yet how often it happens that such persons retain the title of doctor of medicine and expect professional advice for themselves and families at any time and of the best kind, free of charge.

As for clergymen, there is certainly a growing tendency in favor of charging well-to-do clergymen. Indeed, a writer in a recent number of the *British Medical Journal* thinks it is to the interest both of the clergyman and the physician to charge for medical attention. The clergyman is thus more free to choose whom he pleases and is not confined to his own church or denomination; he may summon the physician when he pleases and can demand this attention more as a right than as a favor and can be free to drop one doctor and take another without comment. Again, the minister's pay should be sufficient for all his legitimate expenses, and why should not this include his doctor's bill?

This system is not right for the physician; for although he should not be discouraged from giving true charity and should not practise his profession for its money compensation alone, yet as a laborer, and very hard working laborer, he is certainly worthy of his hire. Of course such ideas are not without exceptions, and as a fact most practitioners do as they please, but in view of the increasing number of medical graduates turned out each year, too much false charity on the part of a profession, which already gives so much, should not be indulged in.

Medical Progress.

REMOVAL OF SUPERFLUOUS HAIRS.

In a paper read before the recent meeting of the American Dermatological Society, Dr. R. B. Morison, of this city, states that he has given up the use of electrolysis in the removal of superfluous hairs. The results which he had had himself, and those which he had seen of others, have not been sufficiently good to warrant its continuance. He finds that the proper application of a good depilatory answers the purpose much better. There are many women who wish to get rid of the white lanugo down on their faces, upon whom it seems that electricity cannot be used for fear of stimulating the growth of the surrounding hair, and the appearance of permanent scars. If a preparation of yellow sulphate of arsenic and quicklime, of equal parts, made into a paste with hot water, be allowed to dry on the hairy skin, it removes the hair for ten to twenty days, and sometimes permanently. On the other hand, nothing seems to take the place of electrolysis where there are a few strong hairs growing from moles, in the removal of moles themselves, in angioma, or in permanent small, red spots.

IDIOPATHIC GANGRENE.

Zeller (*Berl. klin. Woch.*, December 25th, 1893) reports the case of an anæmic young woman, aged 20. Her parents and brothers and sisters were living

and healthy. She had since the age of 12 been subject to attacks of headache and vertigo, supposed to be connected with her anæmia. In October, 1892, she began to suffer from weakness and joint pains in the right upper extremity, and occasionally simultaneously with a sensation of formication in the right hand; the fingers of that hand turned bluish at the tips. On admission into the hospital in December, 1892, the right arm was considerably atrophied and the five fingers were gangrenous up to the middle of the second phalanges. On the following day the gangrenous parts were removed by amputation; the wounds healed slowly by granulation. At the operation it was remarked that the arteries did not spurt, but there was considerable general oozing of blood. No sugar or albumen was found in the patient's urine. It appeared unlikely that she had voluntarily, by some artifice, produced the gangrene for purposes of deception. There was no history of a recent infectious disease, nor anything to lead one to suspect a toxic origin (as ergotism). Zeller negatives the presence of any neuritis or endarteritis proliferans, and inclines to the view that the case is one of Raynaud's disease, the chlorosis possibly acting as a predisposing cause. To account for the asymmetry in an affection described as symmetrical, he suggests that the arteries of the right arm may have been originally of inferior calibre; possibly in connection with a deformity which he observed in the patient's thorax.—*British Med. Jour.*

QUININE IN MALARIA.

Binz (*Centralbl. f. d. med. Wiss.*, 1894, No. 2) reviews our present knowledge of the curative action of quinine in malaria. From his experiments—about 1,867—he concluded that its curative action in this disease was due not to any essential action, as previously supposed, on the nervous system or on the circulation, but to a direct action on the cause of the disease; that quinine was far less a poison for the cells of the human body than for the cause of disease. This was probably some low form of organism, and by removal of which, through the action of quinine, the intermittent crises —swelling of the spleen, the malarious anæmia, etc.—also disappeared. In 1880 Laveran discovered the amœba of malaria. This was found to be affected by quinine, just as the experiments of Binz had shown that the larger infusoria of vegetable juice were by the same drug. It is only when ague gets well without quinine that, according to Mannaberg, phagocytosis can be considered as playing any part, for phagocytosis is hindered by the taking of quinine. The explanation why quinine fails in some forms of ague is that the parasites remain in the blood unaffected by the drug, and even in some such cases, according to Baccelli, the parasites may be affected if the drug be injected directly into a vein, a good result being sometimes possible by this method when administration of the drug by the mouth has failed.—*British Med. Journal.*

THE USELESSNESS OF A MYDRIATIC IN EXAMINING AN EYE FOR GLASSES.

Oculists have for a long time insisted, and some do still insist, on the necessity of using atropia in testing the eyes for glasses. Dr. D. B. St. John Roosa

(*New York Medical Journal*, March 24th, 1894), had always used mydriatics up to the time of his visit at Paris, in 1887, when the work of Dr. E. Javal with the perfected ophthalmometer entirely converted him. The great object in using a mydriatic was not to determine how much hypermetropia existed, but to determine if astigmatism existed, and to what degree. This can be determined in a few minutes by measuring the cornea by the use of the ophthalmometer and by thus taking the difference between the vertical and horizontal meridians of the cornea the rest of the prescription is easy. He has thus ceased to use mydriatics and finds his success with the ophthalmometer justifies his change.

PERMANGANATE OF POTASH AS AN ANTIDOTE.

Permanganate of potash has been recommended and used as an antidote in poisoning and over-doses of morphia, and now an exchange advocates its use as an antidote in phosphorus poisoning, the suggestion being to give from one to two quarts of a one-fifth to one-third per cent. solution of potassium permanganate, this dose to be repeated.

A PALATABLE COD LIVER OIL.

It is said that if warm milk and cod liver oil be well shaken together in a bottle, the result will be a tasteless, odorless and agreeable emulsion of cod liver oil.

AMERICAN CHLOROFORM.

Dr. E. R. Squibb has been making an examination and test of the different brands of chloroform on the American market, and he concludes that on the whole American chloroform is purer than that used in Europe.

GONORRHŒAL RHEUMATISM AND ITS TREATMENT.

Dr. Ramon Guitéras (*New York Medical Journal*, March 24th, 1894) thinks that gonorrhœal rheumatism is a mixed infection which complicates gonorrhœa in about three per cent. of all cases. It is more common in men and age has no influence on it. It appears in about the second or third week of the attack and in two-thirds of the cases it is in the knee, one-fourth in the ankle and one-fifth in the fingers and toes. Its diagnosis is made from the gonorrhœa. It is less severe than acute inflammatory rheumatism and it is usually mononarticular. The serous variety generally ends in complete resolution.

The treatment is varied and generally unsatisfactory. Salicylate of sodium in fifteen grain doses every four hours seems to improve the disease up to a certain point and then it stops. Salol, either alone in five to fifteen grain doses, or if there is neuralgic pain, combined with phenacetin, two and a half grains of each, is recommended. Gaultheria, colchicum and the alkalies have all done good in certain cases. Internal, local and tonic treatment should also be used.

HOW SHOULD THE GENERAL PRACTITIONER DEAL WITH STRANGULATED HERNIA?

Gerster (*Boston Medical and Surgical Journal*, July 20th, 1893) holds that the conduct of the general practitioner in dealing with a case which may possibly be, or is, strangulated hernia, should be regulated with the following rules:

1. In cases of uncertainty give the benefit of the doubt to the assumption that an obscure tumor of the groin is a hernia.

2. Be gentle in attempting taxis, and do not spend too much time over it.

3. Be thoroughly aseptic in herniotomy, and divide the constricting bands freely, not with the probe-pointed knife cutting from within outward, but with the scalpel under the guidance of the eye, from without inward.—*Maritime Med. News.*

HÆMORRHOIDS.

Dr. J. C. Falk (*Medical Fortnightly*), finds that the following combination will usually relieve an ordinary attack of external piles:

℞.—Cocainæ hydrochloratis. gr. vi
Morphinæ sulphatis. . gr. vi
Extracti belladonnnæ. . ʒ ss
Liquor plumbi subacet. . ʒ ss
Ungt. acidi tannic. . . ʒ iii
Ungt. stramonii. . . . ʒ v

Misce. Sig.:—Wash the part with water hot as can be borne for several minutes; dry, and apply the ointment freely. Repeat four times daily and after each stool.—*International Journal of Surgery.*

ACUTE YELLOW ATROPHY IN CHILDHOOD.

After referring to the rarity of this disease in childhood, Merkel (*Münch. med. Woch.*, January 23rd, 1894) records a case in a boy, aged 6¼ years. Seventeen days before his death he complained of loss of appetite and *malaise*, and shortly afterwards he became jaundiced. When he was seen the pulse was infrequent, the temperature 37.4°C., and the tongue coated. The liver extended two fingers' breadth below the ribs. The urine was bile-stained, but contained no albumen. Eight days later the liver could not be felt, and the spleen was enlarged. Later he was seized with convulsions. He then became unconscious, with clonic and tonic spasms. The icterus more marked. The temperature fell to 36.8°C., the pulse being 116. Death occurred in deep coma. Hæmorrhages were found beneath the serous membranes. The lungs were œdematous. The mucous membrane of the stomach and duodenum was covered with mucus. A little bile could be squeezed out of the gall bladder into the intestine. The liver was very small, and on section presented a pale yellowish brown color, with red spots, the marking of the lobules having disappeared. There were ecchymoses in the kidney, and the renal cells showed cloudy swelling, with some fat drops. The liver cells were filled with fat, and round-celled infiltration was seen here and there. The cardiac muscle was also slightly involved. The etiology, as usual, was quite obscure. The author particularly noticed the soothing effects of large rectal injections.—*British Med. Jour.*

TREATMENT OF GONORRHŒAL OPHTHALMIA.

Burchardt (*Centralbl. f. prakt. Augenheilk.*, Nov., 1893) describes the treatment he has found most successful in acute purulent ophthalmia of gonorrhœal origin in children and adults. He formerly carried out the classical treatment of leeching, scarification of the conjunctiva, cauterization with nitrate of silver, and ice compresses. He has gradually omitted all these methods in consequence of some ill effect they had or because they appeared to him irrational, and he

now confines himself to a very free irrigation of the conjunctival sac with a 5 per cent. solution of chlorine water, followed by a 1-10 per cent., solution of nitrate of silver. The head of the patient is thrown back so that he looks directly upwards; an assistant then allows the solutions to fall upon the inner canthus drop by drop, while the surgeon moves the lower lid up and down very freely with the thumbs, and the upper lid more slowly with one of the fingers. bv this means he is able to clear out the conjunctival sac very completely. The success of the treatment appears to lie in the very free movement imparted to the lids, whereby the fluid gains access to all the folds of the conjunctiva. Shreds or membranes are removed from the conjunctiva after everting the lids.—*Brit. Med. Jour.*

TREATMENT OF ALOPECIA AREATA.

Leistikow (*Monatsh. f. prakt. Dermat.*, January, 1894) for the last four years has used chrysarobin almost exclusively in alopecia areata. The results in total alopecia were satisfactory but not reliable; in the partial affection the cures were 58 per cent., but among these relapses occurred in 30 per cent.; of these patients two-thirds were lost sight of, but the remainder were again cured and remained free. Formerly he only used the chrysarobin as a 5 to 10 per cent. ointment applied once or twice daily, but now he prepares a stick composed of chrysarobin 30, colophonium 5, cera flava 35. olive oil 30 parts, the application thus being more simple. Every evening the stick is rubbed over the affected part, which is washed clean with olive oil in the morning. In some days the skin often becomes irritable and red, when zinc ointment is substituted for a time. The author considers chrysarobin the best remedy in this affection.

WOUNDS OF THE TENDONS OF THE HAND.

At a meeting of the Paris Society for Surgery, M. Chauvel reported a case operated on by M. Chupin, in which, as the result of an injury of the hand by the breaking of a glass, the radial artery, tendon of the flexor carpi radialis, and the tendons of the long and short extensors and long abductor of the thumb had been divided at the situation of the *tabatière anatomique*. After ligature of the artery, M. Chupin sutured the tendons *en masse*, but the final result was not very good. In discussing the case M. Berger said that it would have been better to suture each tendon separately. In the case of the tendon of the flexor carpi radialis this is generally easy, but it is sometimes difficult to find the upper end of the tendons of the long and short extensor and long abductor of the thumb, and then the exploratory incision must be made high enough. When the upper extremity of the tendon has been found, it is well to keep it for some time moderately stretched before uniting it to the inferior end, to prevent contraction of the muscle, which will tear the sutures. Berger usually employs two or three points of suture, inserted lengthwise, for each divided tendon, preferring fine silk to catgut, because the latter softens at the end of two or three days. To obtain satisfactory functional results the tendon sheaths should also be sutured with silk. In one case a very good result was obtained

by this method. M. Reclus reported a successful case in which he performed suture of the tendo Achillis three months after its rupture, the ends of the tendon being carefully freshened and united with four silk sutures.—*Sémaine Médicale.*

TREATMENT OF CHRONIC HEART VALVE DISEASE.

Dr. James Tyson (*Amer. Jour. Med. Sciences*) points out that relief is often obtained from the occasional use of purgatives—five to ten grains of blue mass, followed by a saline, or the continuous use of small doses—one-half to one grain thrice daily. The greater apparent effect of the infusion of digitalis is due to its use in larger dose, although it is likely to be better borne by the stomach. Strophanthus, better borne by the stomach, has been used in doses of ten minims every two hours for forty-eight hours without interruption.

Caffein in three-grain doses every three hours, in mitral regurgitation, is admirable, but is likely to produce insomnia. Sparteine in one-quarter, increased to one-half grain dose, three to five times daily, is of value if a diuretic be desired. For irregularity of heart action and palpitation, more common in mitral disease, belladonna is very useful. A belladonna plaster placed over a palpitating heart is a most efficient agent. Nitroglycerine, one-hundreth of a grain, increased to double the quantity, three times daily, often serves to the same end.—*Med. Standard.*

FIBROID GROWTHS IN THE DARK-SKINNED RACES.

Dr. E. A. Balloch (*Medical News*) says it is shown by the independent testimony of English, French and American observers that three diseases are characteristically frequent in the dark-skinned races. These are elephantiasis Arabum, keloid and uterine myomata; and that in general terms they are essentially characteristic of an increasing development of fibrous tissues due to proliferation of the cells around the capillaries; these being increased in number and size. In respect to malignant growths, the same connective tissue type predominates, and he lays it down as a pathological law that there is a peculiarity in the dark-skinned races rendering them liable to growths of a fibrous nature in a degree greatly exceeding that observed in the white race.—*Kansas City Medical Record.*

FORMULÆ FOR REMOVING WARTS.

M. Palm (*Sémaine Médicale*) recommends the following:

℞.—Trichloracetic acid, . 9.0 gm.
Alcohol, . . . 1.0 gm.
Sig. Apply to the wart once daily, or

℞.—Salicylic acid. . .
Lactic acid, . . aa 5.0 gm.
Flexible collodium, . 10. gm.
Sig. Apply twice daily with a brush.
—*International Journal of Surgery.*

BUREAU OF PUBLIC HEALTH.

A delegation of physicians was before the House Committee on Interstate and Foreign Commerce last Wednesday upon the bill establishing a bureau of public health within the Department of the Interior. The bill was prepared by the national quarantine committee of the New York Academy of Medicine, and at this hearing members of the committee, as well as other medical gentlemen, were

present. They included Dr. Gardner, of New York, the secretary of the National Quarantine Association; Dr. R. H. Derby, secretary of the Academy of Medicine; Dr. W. H. Thompson, of New York; Dr. Wm. H. Welch, of Baltimore; Dr H. P. Walcott, of Massachusetts; Dr. George H. Rohé, of Maryland; Dr. George F. Shrady, of New York; Dr. T. M. Prudden and Dr. Wyman, of the Marine Hospital Service.

The proposed bureau is to consist of a commissioner of public health and an advisory council. The duties of the bureau are to collect and diffuse information upon matters affecting the public health; the collection of information with regard to the prevalence of contagious and epidemic diseases in this and other countries; and the preparation of rules and regulations for securing the best sanitary condition of vessels from foreign ports, and for the prevention of the introduction and spread of infectious diseases in the United States. The advisory council is to consist of one member from each State. The bill is a very elaborate one, containing twenty-three sections, and provides in detail for the accomplishment of the objects sought to be attained.

Nearly all of the above-named gentlemen spoke to the committee in favor of the bill. A statement by Dr. F. G. Thomas, of New York, on the general purposes of such a bureau as contemplated in the bill, was read by Dr. Derby. Dr. Thompson followed with a statement bearing on the scientific aspects of hygiene and sanitation, especially with relation to the United States. Dr. Welch submitted a statement of what other countries had accomplished in the lines indicated by the pending bill. He was closely questioned by members of the committee, and explained the various provisions of the proposed measure.

Dr. Walcott then spoke of national quarantine matters in connection with the proposed bureau, and suggested an addition to the Harris bill pending in the Senate on the same subject. Dr. Prudden also made an analysis of the bill, and Dr. Shrady, as editor of the *New York Medical Record*, spoke in its favor. He had watched with interest the movement for the establishment of the bureau, was familiar with the propositions in the pending bill, and felt that such a bureau would be of great benefit to the whole country.

FATTY HEART.

Probably no disease sounds by name to the laity more terrible than fatty heart. That it is a well recognized pathological condition, no one doubts. That physicians use the expression somewhat carelessly, is none the less true. It is possible for a person to have a fatty condition of the cardiac muscle and yet completely recover, as far as we can judge from his subsequent history. The expression, "Fatty heart," is one that should not be carelessly used by medical attendants. Often patients get wrong and distorted ideas of their own maladies, and are thrown into a condition of despair and anxiety, from which they might easily have been free. In the uterus of the puerperal woman the process of fatty degeneration is the one by which the organ is restored to its normal state. After a continued fever the heart itself shows evidence of fatty changes, but they are only temporary. With the

return of health these cardiac changes disappear, and normal tonicity of the organ is restored. So also in anæmia, similar changes result, the heart is weakened and valvular orifices are relaxed. There results a temporary incompetence at the valves, and another cause of murmurs is added to that of the watery condition of the blood. A proper course of treatment removes all this. Repeated hæmorrhages induce the same condition. All these facts go to show that the condition of fatty heart is not necessarily an incurable or positively a dangerous one. This latter element must be determined by the causative factors. Patients are told that they have fatty heart, and this statement they often regard as their death warrant. They live, however, to disprove the prognosis of their advisers. If there are other signs of cardiac trouble than the prognosis is grave indeed, but we should not apply the term "fatty heart" indiscriminately, with its general clinical significance to all those conditions where there may be but slight cardiac changes. —*New York State Medical Reporter.*

THE ABORTIVE TREATMENT OF SYPHILIS.

All competent authorities now agree that the more carefully and thoroughly a syphilitic patient has been treated, the fewer will be the after osseous and cerebral lesions. It is also agreed that treatment is most effective when it is commenced at an early stage of the disease, and followed out in a scientific and painstaking manner. The expectant plan of treatment has led to unfortunate results. No conclusion can be drawn from the fact that the secondary manifestations are mild as to what the later results may be.

Everyone who has had much experience with venereal sores must admit the difficulty of making a positive diagnosis, in the first period of this disease. With this in view, Jonathan Hutchinson recommends that mercurial treatment ought not to be commenced until there is evidence of induration in the chancre. But such experts as Fournier have admitted being wrong in their diagnosis when they relied upon this induration in the chancre as the test for syphilis. It is this difficulty that has induced J. William White to come to the conclusion that it is sound practice to delay treatment until absolute proof is present. It seems to be the opinion of many experienced teachers that it is better to wait until the diagnosis is quite clear, rather than to subject the patient to a prolonged course of mercury for a disease which he has not. Any advantages to be gained by very early treatment are counter-balanced by errors in diagnosis. In some cases, as during pregnancy, or the appearance of suspected sores on the lips, eyes, or nose, immediate treatment is necessary. With such exceptions, it is the proper course to follow to wait until there can be no doubt about the nature of the case.

Cauterization has been strongly urged by some good authorities. Keyes, however, emphatically rejects it. The results have not been very encouraging. The value of cauterization is still surrounded by much speculation as to when the disease ceases to be local and when it becomes general.

The method of abortion by the excision of the chancre has received more

support. If the case be seen early, and the chancre thoroughly removed, and the wound then cauterized, a cure may be effected. Some cases thus treated have never developed the disease. But, here again, we are faced with the uncertainty of diagnosis. Some cases have been diagnosed as true chancre, and regarded as suitable for excision. Under observation for some time, the local sore healed up and no further trouble made its appearance. Had these cases been operated upon, they would have been taken into account to swell the statistics of good results from this plan of treatment.

This plan of treatment is quite different, however, to the attempt to abort by the early use of mercury. Should the disease appear after excision or cauterization, constitutional treatment can then be instituted. But, in the event of the attempt to abort by the use of mercury, and no further symptoms appear, it is not so easy a matter to determine when the drug should be set aside, without fear of an active development of the disease. It may therefore be said that mercurials should not be employed till the first appearance of constitutional infection; that the excision and cauterization sometimes succeed, and are worthy of further trial; and that local antiseptic measures are of no abortive value.—*Dominion Med. Monthly.*

PNEUMONIA.

Dr. Morison (*Lancet*), in several cases presenting the general symptoms of pneumonia in the absence of the ordinary physical signs, has observed a jerky expiration over a limited area, in which he subsequently found developed the usual signs of pneumonia. This jerky expiration is believed to be the first physical sign developed, and can be heard soon, if not immediately, after the rigor, before dullness or crepitation appears. The sign is more distinct in children, but has also been observed in adults. It is suggested that the phenomenon may be due either to the primary congestion interfering with the elasticity of the lung or to the better propagation of the heart-beats through a more readily conducting medium than the healthy lung.

CHRONIC ULCER OF THE STOMACH.

Stepp (*Therap. Monats.*, November, 1893) writes enthusiatically of the good results which he has obtained by the administration of chloroform water in cases of chronic gastric ulcer. The following is an imitation of his formula: Chloroform, *m.* 15; bism. subnit., gr. 45; aq. ad ℥iv—a tablespoonful every hour. He attributes the beneficial effects of the chloroform to its antiseptic, astringent, and hæmostatic properties. At the same time, he believes that it exerts a stimulant effect locally, promoting the formation of healthy granulation tissue and the healing of the ulcer.—*Brit. Med. Jour.*

THE EFFECT OF URINE, NORMAL AND PATHOLOGICAL, ON THE HEART.

Lusini *Arch. di. Farmacol, e Terap.* Fasc. 19, 20, 21, 1893, has studied the effects of normal urine when applied direct to the heart of the frog or toad, comparing it with that produced by the urine of jaundice, tuberculosis, nephritis, scarlatina, measles and pneumonia. He concludes as follows: 1. Normal urine always causes an increase in the extent of the individual heart beats. 2. The urine passed in disease produces peculiar toxic effects directly proportional to the

increase of urea, salts, coloring matter, extractives, etc., as well as to the abnormal matters contained in such urine. 3. The urine of infective disease is far more toxic than that of other common maladies; this appears to be due to the amount of leucomaines found in such urines.—*British Med. Jour.*

OBSTETRICAL PRACTICE "CASH ON DELIVERY."

The fees for obstetrical practice ought to be strictly cash, as, in the nature of the case, there is ample time to make provision for it. We are sorry to say, however, that these fees are not always ready at the time the services are rendered, and, in fact, are too often never paid.

We commend the following from an exchange, as a piece of effective logic:

"Night of delivery, all things *secundum artem.*

"'Doctor, it is not quite convenient to pay you to-night, but if you will kindly wait for a week, it will be all right then.' 'Oh, certainly, it will be quite as convenient then, for I never lose any money on my obstetrical cases.' 'Indeed, how so? Why not?' 'Oh, because it is getting to be a well established superstition based upon facts, that parents who allow their baby boy to start out in life with a debt on his head the first thing, are sure to have a ne'er-do-well, shiftless son, and if the baby is a girl, she is sure to marry a dead-beat.' A peculiar expression came over the father's face, and the mother gave an anxious wandering look at her baby. Half of the bill was paid on the next visit, and the rest soon after.'

Another physician, while attending an obstetrical case where the pay was not considered good, when asked, "Doctor, is the child marked in any way?" answered, "It has only one little mark about it, but you can easily remove that." "What is that, doctor?" "It is marked 'C. O. D.'"—*The Physician as a Business Man.*

ERGOT.

Ergot, in its place, is a most valuable drug. Just after the third stage of labor it is rarely ever out of place, but especially if there is a suspicion of the smallest particle of the membrane or placenta having been left in the uterus, it should be given in proper doses until after the fifth or sixth day following labor, as it contracts the uterine blood-vessels and makes the absorption of decayed material much less liable. Ergot is valuable in other ways, but it is safe to say physicians will meet with fewer misfortunes in obstetrics, who do not use ergot before the third stage of labor. —*Ex.*

THE DELICACY OF VISION.

The delicacy of vision is much greater for lines than for isolated bodies, and particles which cannot be perceived by the unaided vision can readily be distinguished when laid side by side in a row. The smallest particle of white substance that can be distinctly seen on a black ground, or vice versa, is one four-hundredth of an inch square, though it is possible to distinguish particles one five-hundred and fortieth of an inch square, but with great uncertainty. Substances which strongly reflect light can be seen when their dimensions are much less than indicated by the foregoing figures. A bit of gold leaf one eleven hundredth and twenty-fifth of an inch square can be distinguished very easily by an eye of ordinary power.

Medical Items.

The Semmelweiss Memorial will be unveiled at Buda-Pesth on the occasion of the Congress of Hygiene and Demography next September.

The United States Government has ordered Surgeon Woodward back to Hamburg to be cholera inspector there.

The improved sanitary condition of Paris and the new water supply have reduced the mortality there from typhoid fever very markedly.

Dr. William P. Northrup has been appointed Adjunct Professor of Disease of Children, Bellevue Hospital Medical College.

A strong man on exhibition in London lifts two horses with their riders at the same time, the total weight being about four thousand pounds.

Dr. August Ollivier, of Paris, and physician to the Necker and St. Louis Hospitals, and to the Enfants Malades, died recently, at the age of 61.

Dr. Wm. F. Waugh, formerly editor of the *Philadelphia Times and Register*, has moved to Chicago and accepted a position in the Chicago Post-Graduate School and Hospitol.

Dr. J. Hughlings Jackson has retired as physician to the London Hospital after a service of 31 years. He is retained on the staff as consulting physician.

The Maryland Homœopathic Hospital and Free Dispensary of Baltimore City were incorporated last week and will occupy a large building in the western part of the city.

The Medical Association of Georgia will hold its forty-fifth annual meeting in Atlanta, next month, under the presidency of Dr. W. H. Elliott, of Savannah.

The Central Railroad of New Jersey has just turned out a hospital car which will contain all the conveniences for moving the sick and injured. It is something new of its kind, and, if successful, will be copied by all the great railroads of the country.

The Section on Surgery and Anatomy of the American Medical Association will take up the following subjects: 1. Malignant Growths; 2. Tubercular Disease of the Joints; 3. Hernia; 4. Hæmorrhoids, Fistulæ and Fissure; 5. Fractures; 6. Obstruction to Urination in the Male. Dr. John B. Roberts, 1627 Walnut St., Philadelphia, is the chairman of this section.

The Governor of Maryland has appointed the following coroners for Baltimore City: Western disirict, Dr. Pinkney L. Davis; Southwestern district, Dr. P. V. Benson; Northwestern district, Dr. Silas Baldwin; Central district, Dr. Alexander Hill; Northeastern district, Dr. James Billingslea; Eastern district, Dr. Jos. M. Cockrill; Southern district, Dr. Edwin Geer.

The Spanish Royal Academy offers its annual prize on "Clinical and Therapeutical Study of Chronic Affections of the Intestine," and the A. E. G. Cano prize will be awarded for the best essay on "Infectious Endocarditis." Essays may be written in Spanish, Portugese, French, Italian, German or English and should be sent to the Secretary of the Academy, 22 Montera, Madrid, before September 15th, 1894.

The Maryland Legislature has made the following appropriations: Spring Grove Asylum, $35,000, an increase of $10,000; Woman's Medical College, $2,000, $500 increase; Home for Incurables, $2,500, $500 increase; Woman's Hospital, $4,000, $2,000 increase; Baltimore Medical College, $5,000; Southern Homœopathic Hospital, $1,000; and Maryland College of Pharmacy, $2,000.

A physician, in speaking of the business side of the practice of medicine, says: "A doctor will trust people longer and more foolishly than any man on earth. He will go on trusting people for years, until they leave him on account of hating him because they have owed him so much and so long. Then they will go to another physician and pay him, with little or no hesitancy."

In view of the possibility of the reduction of the Medical Corps from one hundred and twenty-five to ninety Assistant Surgeons by action of Congress at its present session, and to save possible loss of time and expense to candidates if such action be taken, the examinations appointed for March and April, 1894, will, by order of the Secretary of War, not be held until further notice. It is probable that if the Corps should not be reduced, the Examining Board will be convened in the fall of 1894. Of this, notice as early as possible will be given.

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MANAGEMENT OF TYPHOID FEVER AMONG THE POOR AND MIDDLE CLASSES.*

BY R. B. NORMENT, M. D.,
OF BALTIMORE.

It is my desire, in the following remarks, to briefly consider the management of typhoid fever in private practice among the poor and middle classes. I have no series of brilliant achievements to relate, no new theory to expound. Actuated by a desire to learn rather than by a desire to instruct, it is my utmost hope that the few remarks I shall make may provoke a discussion among those present—for I make no doubt that the experience of a majority of my hearers in treating this disease has equaled, and in many cases exceeded, my own—and that as a result of this discussion, we may depart the wiser for having given consideration to, and compared notes concerning this serious and interesting disorder.

While I am philosophic enough to see that the opportunities for recovery from this disease, as well as most others, are greater in a well regulated hospital, with its ideal ventilation, its regulated diet and manifold conveniences, its trained staff, both of physicians and nurses (and I am visionary enough to believe that "as the long train of ages dies away the sons of men" will come to appreciate this fact) and advanced civilization and education will produce such changes in social conditions that the work of medi-

*Read before the Clinical Society of Maryland, March 9th, 1894.

cal men, so far at least as the treatment of the more serious diseases is concerned, will be conducted almost exclusively in institutions conducted and equipped for the care of the sick; still, within the lifetime of those within my hearing, I feel sure that the great majority of cases of typhoid fever will be treated by the general practitioner, in the private dwelling, with the aid of such nursing as may be within easy reach—generally unskilled, often ignorant and superstitious as well—and the greater number of these cases will occur among those classes of society known as the poor and middle classes. So that it strikes me as not inappropriate for one whose experience has been entirely among these classes to give a few deductions from it, even though that experience has not been very rich either in point of the number of cases treated or the brilliancy of the results attained. As it is only the management of the disease about which I desire to speak, I shall not weary you with even a short résumé of the clinical history, etiology or pathology. Save what few remarks must of necessity enter into the discussion, *treatment*, and treatment *only*, shall demand our attention this evening.

I shall endeavor as briefly as practicable to give my views under the following heads: 1, General Management. 2, Special Symptoms. 3, Complications. 4, Convalescence. 5, Prevention.

1. *General Management.* — Much stress may be laid upon the value of an *early* diagnosis, not so much that it enables us to cut short the disease—for I frankly confess that I have *no faith whatever* in any abortive treatment—as that by a plain statement of the character of the disorder the patient and his friends may be kept from certain imprudences which are of harm to both sick and well.

I have often been requested not to tell the patient the nature of the disorder; I have invariably advised against this course except in hysterical females and persons of feeble mind. Even in these I believe it is often best to take the patient into our confidence, but whether this be so or not, as a general rule, let the patient know his condition, plainly and fairly telling him of its dangers and cheerfully holding out to him its hopes. We are thus very often enabled to induce the patient to take that good care of himself in the early part of his attack, which I believe is the very best means of warding off most of the dangerous conditions which are to be found later on. These remarks apply, of course, to those cases in which the patient is rational when we first see him—no one would be foolish enough to advise counsel with a patient even moderately delirious. Care and attention will generally enable us to make a diagnosis early. All cases of continued fever, however mild, when not clearly due to some other cause, should be looked upon with suspicion, more especially if typhoid fever exists anywhere nearby, receive our careful consideration, and so soon as any really just suspicion of the disease becomes manifest the patient should be put to bed—a comfortable bed in a well ventilated room as free as possible from noise and excitement.

A few words about the bed, bedding,&c.

When we consider the liability to sudden and troublesome complications which is always present when we have to deal with this disease, we may well take care to see that our patients are so placed as

to make necessary the smallest possible change in the general arrangement of affairs in case of their onset. Whenever practicable, the typhoid fever patient should be placed in much the same surroundings as we would place a patient suffering from troubles demanding surgical attention; that is to say, the bed so placed as to be accessible from both sides, not too wide, made of a firm mattress supported on a woven wire spring, and this on a good, strong bedstead. Simple as these things are, and desirable as they must be admitted to be, they are entirely beyond our reach when we have to deal with a patient living in a small and crowded house, no bedsteads save double ones at hand, no mattress on the premises—old feather beds and strawticks the only bedding to be had. Under such circumstances much may be added to the patient's comfort by folding several heavy quilts or comforts and spreading them smoothly over the well beaten bed. Let it be insisted that the patient and his nurse shall be the only occupants of the room; by all means possible let no one else sleep in the apartment. The patient should wear but little body-clothing; a well-made gown is the best possible dress for male or female. Let comfort, so far as temperature is concerned, be brought about by light covering for the bed and the temperature of the room kept equable. I would emphasize this point as to the small amount of body-clothing, as it aids very materially in having changes made at regular intervals. Let the bed linen and body clothing be changed frequently whenever patient is strong enough to permit it. For myself, I can see no harm in allowing the patient, provided the abdominal symptoms are not violent, to be helped into a large chair or recline on a lounge while the bed is made once a day, or even twice. The change of position is restful and the well-made bed is a genuine luxury. Let the bed be so placed as to be as free as possible from the influence of draughts and so that the sunlight admitted into the room shall not shine in the patient's eyes; do not let a large mirror hang where reflections of the light (day or artificial) will shine in his face. Let the room be well ventilated. Among the poor and ignorant it is often very difficult to have this very desirable and important item properly attended to; sometimes it is well-nigh impossible to have outside air constantly admitted; though tact on the part of the physician will usually accomplish the purpose. When it cannot be continuously admitted, see to it that it is for a little while and at short intervals. Happily we do not have as much trouble on this score now as we did some years ago, when it seemed to me that everybody I met deemed it a good thing to make all fever patients "*sweat*" and plenty of cover and a close, warm room seemed to be regarded as prerequsites to recovery. Let the patient's body, as well as his clothing, be kept clean; sponging with tepid water once in twenty-four or forty-eight hours is usually grateful and beneficial. The prejudice against this course, still frequently encountered, may often be overcome by the addition of a little vinegar or alcohol to the water. I think it advisable to persuade female patients to have their hair cut early in the attack as it nearly always has to be done afterward, and the comfort of the patient is greatly conserved by its absence while she is in bed.

The *Diet* of typhoid fever patients should be fluid absolutely, from the first onset of the disease until convalescence is established. Milk, beef-tea, mutton broth, raw eggs, barley and rice water will suffice in most cases and are usually more acceptable to the patient than the commercial articles so highly lauded by the agents of their respective manufacturers—meat juice, peptonoids, Liebig's food, etc., etc. In the earlier stages I believe it is best *not to insist* upon the patient's taking any nourishment at all. If he desire it, let him have it in moderate quantity (a teacupful) and at short intervals (two or three hours). But forced alimentation in a conscious patient, especially in the early part of his illness, is in my opinion productive of nothing but harm. We may feel convinced of the safety of this suggestion when we remember that some intelligent and supposedly truthful writers advise a diet composed of nothing but *water* during the first two weeks and report good results from this plan of treatment. Water may be drunk freely, only taking care that it is not consumed in sufficient quantity to overdistend the stomach and by its bulk cause discomfort and vomiting. Let the physician when practicable see his patient morning and evening.

Medicinal Treatment.— The average American must and will be dosed when he is sick, and to treat a typhoid fever patient *without medicine* would be a crime unpardonable in the eyes of his friends, among most of the residents of our city. So the patient must have medicine—what shall it be? A gives quinine and gets good results; B gives the mineral acids and gets excellent results; C relies upon alkalies and as many of his cases recover as those of any one; D (our homœopathic friend) gives questionable infinitesimals combined with sugar of milk, and, mirabile dictu, his results—to hear him tell it—are as good as the best of us can boast. With such an array of testimony what shall we do? For myself I have given quinine and I like it. I ordinarily give 1½ or 2 grains dissolved in one of the mineral acids with simple syrup every four hours.

When the skin is dry and the lips parched I often use the following mixture:

℞.—Potass. chlorat. . . . 3ss
Sp. Aeth. nit. 3vj
Liq. Ammon. Ac. q. s. ad. . 3iij
S.—3ij every three or four hours.

Sometimes I have used 2 or 2½ grain capsules of the *bisulphate* of quinine (being careful to see that they are fresh and put up dry), alternating with the mixture referred to. These, with a moderate amount of alcoholic stimulation, will suffice in many cases.

This is perhaps as good a time as any to say a few words concerning the use of alcohol. I am afraid I have in the past been too fond of giving this remedy, yet under certain circumstances I must say my faith in it is very strong. But I can not say that I believe in its administration as routine treatment, especially in the early stages of the disease. When weakness is a pronounced symptom, when hypostatic congestion of the lungs is present, the free administration of good whiskey has seemed to me to be of the greatest service. But when it is to be continued for many days, I believe two or three fluid ounces is as much as it is advisable

to give, and many cases will get along perfectly well without any. I can not, however, too strongly emphasize my belief that *rest in bed*, quiet surroundings, pure air and an absolutely liquid diet constitute the sheet-anchor of the treatment of typhoid fever; and when these are faithfully carried out from first to last, complications will be fewer in number, and violent cases will be much reduced in frequency. So much for the general management.

Special Symptoms. Temperature. — When this does not exceed 103°F. and it is the only pronounced symptom it may well be let alone. When it rises above this point, the bath in one form or another is undoubtedly the most reliable means of reducing it. My experience is limited to the sponge-bath, and when well carried out, I see little more to be desired; at any rate it is the only bath generally in reach of our patients. The full bath requires conveniences and nursing which are beyond the reach of most people. A piece of oil-cloth to protect the bed, together with water about 90°F., are easily obtained in most households and the simple direction to sponge the patient till it ceases to be agreeable to his feelings, can be carried out by any nurse of average intelligence and self-reliance.

Among medicinal agents looking to the same end I would mention with favor aconite and bromide of potassium in combination, antipyrine in five grain doses while the temperature exceeds 103°F. and phenacetine alone or combined with quinia. Phenacetine, while perhaps the most reliable of the antipyretics, should be used with caution, as it is certainly very depressing. Five grain doses should not follow each other at closer intervals than three or four hours; and when the nurse is not more than ordinarily reliable should not exceed two in number between the visits of the physician. Tr. aconit. rad, gtt. iij, combined with potass. bromide, gr. x every two or three hours, sometimes has a wonderful effect in reducing temperature, when the latter is accompanied by a hard pulse and delirium. Antipyrine is perhaps the best of the antipyretics when headache is the principal accompaniment of high temperature.

Delirium and high temperature are so often seen hand in hand that they might almost be considered each as a part of one symptom. The remedies already spoken of as beneficial for the relief of the pyrexia will often suffice for the delirium as well. When they do not, various drugs may be found of service. When the skin is hot and dry and the delirium inclined to be boisterous I have found nothing better than a combination of morphia and tartar emetic.

When the skin is moist, belladonna or hyoscyamus with the bromides often answers well. When delirium is maniacal I place my faith in chloral. As to all of these remedies, I think the following a good rule: Whenever we need them at all we desire a prompt action; one full dose is better than several smaller ones, whichever we may decide to use. Cold to the head and counter-irritation of the nape of the neck are often of service.

Stupor.—This symptom has not been one of frequent occurrence in my experience. When very pronounced, it is one of the very worst symptoms and augurs evil. When it exists I believe the proper

lines of treatment consist in maintaining the proper action of the bowels and kidneys and keeping up the strength of the heart's action. For this latter purpose I place more faith in alcohol than any other remedy. If diarrhœa exists in this state or that of coma-vigil, I think a careful analysis of the case will generally show it to be due to paresis of the lower bowel, rather than to increased peristalsis. Nux vomica and camphor have seemed to me to give better results than anything else I have tried, under these circumstances. If the kidneys are not acting freely, counter-irritation over the loins may prove of service.

Vomiting is also, in my experience, rarely a very serious symptom except in young children and in cases where opium or morphia have been used, the patient presenting the very common iodosyncrasy against that drug. I might say that I think I have seen the same symptoms produced by the too free use of whiskey. It may ordinarily be checked by counter-irritation of the epigastrium and the free administration of subnitrate of bismuth when the bowels are loose, or by small doses of calomel frequently repeated when they are constipated, even though only moderately so.

Diarrhœa.—This symptom is the cause of great concern to most practitioners. For myself, I would place the number of stools to be considered as demanding treatment at six in the twenty-four hours rather than at two or three, as ordinarily stated. At the onset of the disease a moderate diarrhœa is, in my opinion, good, provided harm be not done the patient by too heroic treatment for its relief; the constipation following the cessation of the diarrhœa has seemed to me to be more harmful than the diarrhœa. I would not, however, advise anything like carelessness with regard to this symptom. Let it be particularly inquired into *while it is mild,* and see if the diet, whatever it may be, is not disagreeing. A careful regulation of the *quality* and *quantity* of nourishment is often all that is needed. Let us not think that milk is always a good diet in this disease. When regulation of the diet does not suffice, bismuth alone or combined with one of the vegetable astringents—I ordinarily use geranium or hamamelis—administered *per orem*, tincture of opium per rectum, are usually the best remedies.

Constipation.—Some writers, indeed, I believe the majority state that constipated patients generally do well. I am afraid of a constipated typhoid fever patient. True, if the constipation consists only of tardiness of peristaltic action of the bowels, the stools being semi-solid and passed at intervals of thirty-six or forty-eight hours, all is well so far as this symptom is concerned.

But when a longer interval supervenes, especially if the patient be taking milk freely, beware! Decomposition of the imperfectly digested milk is liable to occur, or the caseine to become impacted. In the former case uncomfortable tympanites is likely to result; in the latter violent tenesmus when the bowels do move, followed by profuse and intractable diarrhœa, not to mention the increased risks of hæmorrhage and perforation which I think common sense would say are more likely to occur when large and hard masses are passing over the ulcerated surface and violent efforts must be made for their expulsion, than when the stools

are liquid and easily passed. As for remedies for constipation, I have been in the habit of ordering the enema in families, where I thought it would be given with proper care; but simple as is this procedure, it is not always safe to trust to an ignorant or careless nurse, with, it may be, an imperfect syringe to use. Among that class who do not possess either instrument or nurse, I have of late ordered magnesiæ sulph., ℥i every three hours, until the bowels are moved and I have had such favorable results from the use of this salt, that I am not sure but that I shall discontinue the use of the syringe even where I have a reliable nurse. When I must use medicine I would give this the preference over all others in this condition. I feel fully convinced that by the prevention of obstinate constipation in the second and third weeks of the disease results the saving of much trouble later on.

Tympanites.—As I have already intimated, I believe that in the regulation of the diet and alvine discharges rests a great deal of prevention of this symptom, troublesome and disagreeable as it is. Where it is present, oil of turpentine is the best remedy with with I am acquainted. Turpentine stupes to the abdomen also seem to be of service, but *why* or *how* I could never guess.

Intestinal hæmorrhage, when mild, will perhaps often be controlled by absolute rest, but on this point I cannot speak from experience, for I have never been bold enough to let a patient alone when he had passed a bloody stool. Indeed, I am in the habit of leaving a bottle of ergot (Squibb's fl. ext.) at the house of my patients after the second week, with directions that should patient have a bloody stool, he be immediately given a dose (f℥i) and I be sent for. Though while I have done this I cannot say that I have the confidence in ergotin active or violent hæmorrhage that I have in gallic acid. My course in severe hæmorrhage is as follows: Place the patient absolutely at rest, let him make no exertion whatever. If he cannot pass his urine without changing his position, use the catheter. Should there be nausea, as there frequently is, it is a symptom of cerebral anæmia; elevate the foot of the bed, place a sinapism over the epigastrium; administer gallic acid and opium freely. When there is great thirst endeavor to quench it by the use of crushed ice, instead of water. When the hæmorrhage has ceased, as indicated by the general condition of the patient—for it goes without saying that the amount of blood which has escaped from the bowels is no reliable index as to the severity of the hæmorrhage—be especially careful not to disturb the stomach and bowels by too free a supply of nourishment. If the hæmorrhage be but trifling and the patient quickly rally we may well leave the bowels to nature. If a large hæmorrhage has occurred, it is best to keep the patient constipated for several days by the free use of opium.

Perforation.—As I have never seen a patient, in whom I thought the suspicion of perforation justified, recover, I do not feel called upon to say anything concerning this terrible accident save that, if the bowels are kept free from hard and irritating fæces, it will not be nearly so likely to occur as when the opposite state of affairs prevails.

Severe abdominal pain should be treated on general principles. Where no cause is assignable, morphia is perhaps the

best of internal remedies. Poultices of linseed meal, to which a little laudanum has been added, are sometimes of service. I have seen one case in which the pain was caused by spasmodic contraction of a portion of the intestine. In this case a tympanitic tumor as large as an orange would form in the right iliac region, remain a few minutes, during which time the patient seemed to suffer excruciating pain, then the tumor would disappear, only to reappear again in a few minutes. This patient was relieved by a large enema containing tr. assafœtidæ f ℥ss, followed by the administration of chloral.

Complications.— The principal complications I have met with have been hypostatic congestion of the lungs and bed sores; though there is no end to the number and variety of complications which occasionally occur. Among those that are rather unusual I may mention earache and toothache, and during convalesence, rheumatism. All these may be treated on general principles.

As for hypostatic congestion, it is usually caused by a weak heart. Its prevention is better than its cure; frequent change of position and a proper amount of alcoholic stimulation are the best preventives. When it has occurred the same remedies used for its prevention are of service. In addition, turpentine, camphor, ammonia, are all serviceable at times; but "life is too short and time is too fleeting" to give all of them a trial in any one case. I would recommend ammonia in the form of the aromatic spirit, unless the abdominal symptoms are severe, when I would most heartily endorse good doses of oil of turpentine, *m*x every three or four hours.

Bed Sores.—My experience with these abominations has been a peculiar one. While in most of our text-books they are alluded to as being indicative of a fatal termination, I have never seen typhoid fever terminate fatally when this complication existed; though I have been sorely troubled about several cases in which they were present, and I declare I do not know why they *didn't* die. With bed sores, as with other complications, prevention is far better than cure, and most of the remarks regarding hypostatic congestion will apply to these as well. In addition, let the parts of the body most exposed to pressure be frequently bathed with whiskey and alum, and as far as possible remove all pressure from any point threatening to ulcerate. The application of resin cerate when the skin is reddened will be of service. When the trouble goes further, and there is no hope of prevention, I have been impressed with two varieties of sores, the one tending to become phlegmonoid, the other gangrenous. In the former free incision as soon as the presence of pus can be diagnosed, followed by a good hot poultice, is the best treatment. In the latter apply poultices till sloughing is well advanced, then use frequent antiseptic washes and alsorbent dressings. When the ulcers resulting in either case have ceased to slough, the treatment most applicable for ulceration is all that we can adopt. There is one other complication, which occasionally occurs, about which I would like to say a few words, and that is:

Pregnancy.—In no work that I have examined does it seem to me that this complication has received the attention which it should. And I believe it is due to the fact that few of our best authors

are eminent as physicians and obstetricians at the same time; the writers on practice are specialists in practice, the writers on obstetrics are specialists in obstetrics. while the great mass of patients suffering from typhoid fever fall under the care of general practitioners, who are specialists in neither, and whose writings do not come into general use, or occupy a prominent place in medical literature. True, the subject is mentioned and some statistics given in almost every treatise, but little of practical value is mentioned, especially so far as the treatment of the condition is concerned. The subject, while usually dismissed with a single page or less, is one that would furnish good material for a special paper. The limits of the present article will permit me only to give a cursory mention, and leave it for abler hands to deal with it more fully at some other time. I have seen typhoid fever and pregnancy co-exist in three instances; two during the first three months and one during the ninth month of pregnancy. All these patients were multiparæ; in all the pregnancy terminated during the illness; all recovered; all have since borne children. From my experience in this very limited number of cases I am led to believe that the best course to pursue is, let the pregnancy alone till abortion or premature delivery threatens; then aid the process by all reasonable means. As any treatment looking to prevention of abortion is likely to prove futile, the sooner the uterus is empty the better. When abortion or premature delivery is complete, use the same antiseptic treatment as for puerperal sepsis.

Convalescence.—The management of the convalescent among the classes we are considering is perhaps among the most difficult problems of the treatment of cases as they ordinarily occur, and especially of the milder cases. The ravenous appetite, coming before the temperature has fallen to a proper level, and patients begging hard for articles of food, the very mention of which almost makes the practitioner's hair stand on end—bacon and cabbage, pork, baked beans, cheese, I have been begged for all of them—are very annoying to the practitioner; and the fact that foolhardy nurses have been known to give this class of articles to such patients without harm resulting therefrom, despite the fact that the physician had most urgently discountenanced and forbidden their use; or men careless as to their observations *"have seen good follow"* such abuses (for it may well be believed, that under these circumstancea *any food that is digested* will give strength and comfort to the patient). I say all these things make it exceedingly difficult to control our patients at this time. The patient's room, particularly in warm weather, is often on the same floor with the kitchen, and sometimes when he is hardly able to sit up with safety, he will, if the opportunity offer, make the short excursion and procure the forbidden fruit himself. Meddlesome visitors are often to blame. A hard fact, but nevertheless a fact, is that these acts of disobedience, whether on the part of patient or nurse, are usually not made known to the physician till after the probability of harm has passed, then only in cases where no harm was recognized. Nevertheless, we should not be deterred from insisting to our patients and their friends upon strict

care with regard to diet at this stage of the disease, and see that no solid food is allowed till the temperature falls to 99° F. in the evening and remains so for two days; and that when changes are made they shall be gradual. The same rule as to rest will be found a good one. Keep the patient in bed, save for a little rest in the chair while his bed is made, till the temperature falls below 99° F. Let him after this time sit up a part of each day, gradually lengthening the period, allowing day by day an increase of diet, seeing that the meals are given frequently enough to avoid the necessity of large ones. Let him have pleasant company, but do not let his hours of rest be interfered with. Beware of exercise while much bodily weakness remains. Violent exertion should be avoided for several weeks after the establishment of convalescence, especially in case of those who have suffered from intestinal hæmorrhage or severe tympanitis during the attack. Alcoholic stimulants should be given in small and constantly decreasing amount. If the patient seem to be recovering rapidly he *needs* no medicine, but a little iron will not hurt him, and may be given to save him from being dosed with some quack nostrum. If he gains strength slowly let him take a ferruginous tonic—the tr. ferri. chlor. answers about as well as anything. When patient has regained a sufficient amount of strength to make it prudent, exercise in the open air on good days is of service in this as in all other troubles.

Prophylaxis.—No question in connection with this disease should receive more careful consideration at the hands of physicians. Every typhoid fever patient should be regarded as a menace to the safety of the community, more particularly in neighborhoods where the water supply is derived from wells or springs, and the discharges and slops from the patient's room are emptied into privy-pits not far distant. I think it may be taken for granted that the alvine discharges are the potent agent in disseminating the disease. This being so, care should be exercised in every case to see that they are rendered as nearly harmless as possible, that the water supply may not be polluted thereby, and also to see that if there is any probability that the water supply is already infected, it be rendered harmless also. Fortunately simple procedures, if properly carried out, will accomplish both of these results with a fair degree of certainty. For the former purpose I think the following simple expedients will answer well: Let a handful of copperas, or, where this can not be procured, lime be placed in the vessel with each stool, add one or two pints of boiling water, cover the vessel and let it stand for an hour or two before it is emptied. If the privy-pit has already been used by the patient, let one or two bushels of quicklime be thrown into it and enough water to slake it, should there not be sufficient semi-fluid fæcal matter to accomplish that purpose. As for the drinking water, insist that every drop that is used shall be boiled, and that thoroughly. I believe that these simple means will, if well carried out, prevent the spread of the disease as well as any ordinarily within our reach.

At the outbreak of the disease, its source should always be traced if possible, and such means as circumstances will allow be used for the protection of others.

320 Falls Road.

THE RELATIONS BETWEEN SALPINGITIS AND APPENDICITIS VERMIFORMIS, AND THEIR IMPORTANCE TO THE GYNECOLOGIST*

BY J. T. BINKLEY, JR., M. D.,
OF CHICAGO.

Probably no subject in medicine or surgery has occasioned so much talk among the laity and created so much interest in the profession as appendicitis. Dr. Richardson, of Boston, says: "I am firmly convinced that appendicitis is the most important acute abdominal disease of the present time." Every gynecologist appreciates the importance of tubal affections. The relations between these regions in the female must then be considered of vital importance to the gynecologist.

It is not my purpose to dwell especially upon the affections, or to rehearse the pathology of the uterine appendages, but rather to present to you a résumé of the opinions of a few of the most experienced writers upon the subject of the appendicitis vermiformis, and to add my own limited experience in these affections.

Anatomically the appendix does not differ in structure from the intestine; its walls are composed of four coats, mucous, connective tissue, muscular, and serous. Its average length is about four and one-half inches, and its size about that of a No. 9 English sound. The lumen is very small, and the cecal orifice partly closed by a valve. In location it is very variable. It originates from the posterior and inner side of the caput coli, and, according to McBurney, is usually to be found directly under the middle point of a line drawn from the umbilicus to the anterior superior spine of the ilium. The free extremity of the appendix may radiate in any direction from this axis around the head of the colon. In two hundred cases examined by Ferguson it was directed inward in eighteen cases, downward in eleven cases; it was in relation with the head of the colon posteriorly in seventy-five cases, and was so placed in the iliac fossa in seventy-seven cases that a perforation would take place into the retroperitoneal cellular tissue. The few cases in which the appendix was directed downward, according to Ferguson's statistics, are difficult for me to understand. I have seen five consecutive cases with the appendix pendent, but all of these cases were females, whose broad pelves invite the descent of the appendix; and it may be that Ferguson's observations were upon men, whose vermiform appendices do not so often descend into the pelvis. Dr. Briggs, of the New York Post-Graduate Medical School, states that in "three-fourths of all cases the appendix is directed below." Dr. F. Byron Robinson has found the appendix over the brim of the pelvis in twenty-five per cent. of all cases which he has examined.

It is in this dependent position, when inflamed, that the appendix presents the most interesting features to the gynecologist. I have twice found it attached to the Fallopian tube, but apparently not diseased. I once saw it firmly adherent to a large pus tube, from which it had been infected; I recently assisted Dr. Steele in removing an appendix thus

*Thesis read before the Chicago Gynecological Society, January 19th, 1894.

located, and Dr. Martin found the appendix attached to and penetrating a large tubal abscess, which it had probably caused.

In order that I may better illustrate the points which I desire to make in this paper, I wish to report briefly the following cases:

Case 1.—Mrs. W., a widow, called at my office in October last. She presented the following history: Age 43 years, married seventeen years. Her first and only pregnancy, sixteen years ago, resulted in a miscarriage in a few weeks after conception. From this mishap she evidently recovered. Her present illness dates back two years, the only symptoms being occasional pain in the thigh and daily fever. The examination was negative. The patient weighed one hundred and eighty-six pounds. The abdominal wall was about four inches thick and the vulvar cushions two or more inches in thickness. Bimanual palpation revealed little more than the outline of the uterus. By means of the sound I discovered that the uterus was in normal position. Through the speculum I saw no pathological conditions and rectal examination was negative, but excluded hæmorrhoids.

My diagnosis of pyosalpinx was made principally from the reflected pain in the thigh, and the slight elevation of temperature in the evening. This reflected pain down the obturator, or anterior crural nerve, into the thigh, and the local pain produced by moving the neck of the womb laterally while the patient stands erect, have proven in my few cases of salpingitis almost pathognomonic signs. Upon opening the abdomen the uterus was found high up and the tubes reflected to the sides of the pelvis, then downward and backward, and were firmly adherent in the pelvic fossæ. To the right tube was attached what I first thought to be a knuckle of the small intestine, but which proved to be the appendix. I caught a fold of its mesentery with a pair of catch forceps, then separated the slight adhesions without difficulty, with the intention of bringing the mesentery and the appendix into view; but the mass slipped from the forceps and disappeared. Owing to the thickness of the abdominal wall, and other complications encountered, I did not again secure it. The adhesions of the tubes, which were quite firm and extensive, were separated, after a tedious dissection with the finger, and the tubes and ovaries were ligated and removed. The abdominal cavity was thoroughly flushed with hot sterilized water and closed without drainage. The patient left the Chicago Hospital at the end of six weeks, and walked two blocks to her home.

Case II.—Mrs. J. M. P., aged 43 years, mother of three grown children; no miscarriages; no history of pelvic inflammation; menstrual function regular and normal. The only symptoms were a recently developed pain over the region of the cecum and a reflected thigh pain of longer standing. Examination revealed a cystic tumor on the right side the size of a turkey egg, apparently within the broad ligament. I advised operation, and sent the case to Dr. Franklin H. Martin for his opinion. Dr. Martin concurred in my diagnosis, but added: "The tubes are also infected, in my opinion." Upon opening the abdomen, in the presence of Drs. Martin, White and assistants, the tubes were

found enormously enlarged; they projected from the uterus to the sides of the pelvis, and were as firmly attached as were the tubes in the first case. A cyst from the right ovary had extended between the folds of the broad ligament, and the tube was in consequence lifted up an inch or more. In a fold or crease between the ovary and the tube the appendix was firmly attached for about an inch and a half of its lower extremity. The removal of the appendix seemed advisable, as I feared that hæmorrhage might follow the breaking up of adhesions. This was easily accomplished, because the head of the colon lay well down over the brim of the pelvis and toward the median line. Both tubes were diseased. No drainage was required. The operation was done two weeks ago, and the patient is now doing well. (Specimens exhibited.)

Case III.—The third case demonstrating this most important subject recently came under my observation in Dr. Martin's service at the Chicago Hospital. Mrs. E., age 36 years, married fourteen years, two children 12 and 7 years of age; one miscarriage four years ago, at ten weeks' gestation; not since pregnant; had typhoid fever and pelvic inflammation two years ago. Last July she had another attack of pelvic inflammation, followed by a tumor in the right iliac region, attended with pain down the right thigh and a discharge of pus per rectum. Diagnosis: pyosalpinx on the right side complicated by appendicitis.

Laparotomy revealed a large, encysted tubal abscess adherent to the head of the colon and to the omentum. After separating these adhesions, the appendix was found to have penetrated into the centre of the abscess and to be firmly adherent to its walls. Upon examination of the mass after its removal the appendix was found to be perforated at its distal extremity, thereby making a direct open canal from the caput coli to the dilated Fallopian tube. The left tube was not diseased. The perforated extremity of the appendix had become attached to the Fallopian tube; its infectious microbes had caused ulceration and perforation of the Fallopian tube, and planted the seed in its lumen which had grown and multiplied until a pint of pus was the result. Whenever distention of the tube occurred its contents were expelled through appendix into the bowel and passed per rectum.

The above reported cases clearly demonstrate several important factors which specially interest the gynecologist. Two great classes of cases are here represented: first, those in which the appendix is infected either directly or indirectly by the tube; and second, those in which the appendix plants the infection in the tube. In the first class we have the enlarged and inflamed tube presenting an attractive surface to which the wandering appendix may become attached. As the result of this attachment there may occur a direct infection of the appendix by the transmission of microbes directly through the walls of the tube and the appendix, according to the theory of Dr. F. B. Robinson, or the appendix may become infected indirectly by being bent upon itself, or by having exudations thrown above it, causing constricting bands. These bands and bends produce obstruction, and the obstruction causes foreign particles to be retained, and salpingitis naturally results.

Dr. Martin's case is a beautiful example of the second class; it shows the manner in which the tube may become infected from the appendix. Of course it is not impossible in this case for the infection to have come about as in the other two cases, but it is highly improbable. The history of recurrent pain in the appendicular region, followed by tubal abscess, only upon the right side, without infection of the left tube, points to the appendix as the seat of infection.

The first class of cases I should consider less dangerous to handle than the second, because the appendix is often attached only by its mesentery or by its external surface, without perforation or other pathological lesion, and it may be left after separating it from the tube. I should not, however, advise its being left, unless, for instance, symptoms of shock should make it necessary to quickly conclude the operation. The operation might be unduly prolonged on account of the difficulty of ligating the appendix through a median incision, and especially would this be the case in fleshy persons with the appendix long and a high caput coli. In the second class of cases, however, where the tube is the primary seat of infection, it is usually perforated, and cannot be left in the abdominal cavity, but should be taken out, if possible, as soon as discovered.

What, then, are the lessons taught by these cases? First, that greater care must be exercised in freeing the uterine appendages from the adhesions upon the right side than upon the left; second, that all detached tissue upon the right side should be carefully examined with the expectation of finding an adherent appendix, which, if found, should be removed. I should strongly advise its removal in every instance where it has once been adherent, because of its tendency to become adherent to various points on the peritoneum.

After carefully considering the peculiar tendency of the appendix to become adherent to the surrounding viscera, and knowing that pain is the dominant symptom of such adhesions, it seems probable that this body may be responsible for a large percentage of the colic and reflected pains that follow laparatomies.

Our deductions from Dr. Hektoen's statistics are that four per cent. of all women have appendicitis. A large percentage of the patients who call upon the gynecologist are probably of this class, and seek advice, not because of appendicitis, but because of reflected pains which they refer to the uterus. Dr. Robinson states that he has observed in the examination of one hundred cases that the left tube has the larger lumen, and is infected nearly twice as often as the right tube. No doubt, therefore, the smaller lumen and orifice in the right tube tend to prevent the invasion of infection from the uterus, and the appendix is responsible for the infection of the right tube more frequently than is generally supposed. These statements of Drs. Hektoen and Robinson strengthen the claim that the appendix is a body of great importance to the gynecologists.

In the three cases here reported, and in two others, making five in all that have come under my observation recently, I have found the appendix hanging over the brim of the pelvis. I regret that I

did not observe and record its position in a large number of laparotomies at which I have assisted during the past few years, because this report would then be of more value from a statistical standpoint.

I believe that the chief cause of downward position of the appendix in women is the shape of the pelvis, which is broad and flaring, and does not have the forward ridge or angle of the pelvic brim under the head of the colon which is found in men. Two other factors occur to me which favor this position of the appendix: first, the corset, which tends to force it down; and second, childbirth, which relaxes peritoneal attachments.

Venetian Building.

PRECAUTIONS TO BE TAKEN AFTER DEATH OR RECOVERY FROM THE ACUTE INFECTIOUS DISEASES.

The *Union Médicale* for January 27th contains an article on this subject in which the writer says that, if death follows an infectious disease, the body should be prepared for burial as soon as possible. It should be bathed in a 1-to 2,000 solution of corrosive sublimate and put into a coffin and packed with sawdust which has been thoroughly wet with the same solution. The interment should follow with as little delay as possible.

If the patient recovers, isolation should still continue, and he should not come in contact with others until a sufficient length of time has elapsed, according to the nature of the disease. The *Académie de médecine* has decided that isolation should begin from the day when the eruption first appears, and continue for forty days in small-pox, scarlet fever, and diphtheria, and twenty-nine days in chicken-pox, measles, and mumps, and should not end until after the patient has taken two or three baths, followed by thorough friction (including the head). These precautions may seem somewhat rigorous for ordinary practice and they may be modified, at least in light cases, where, after convalescence, one bath lasting half an hour is sufficient. All clothing belonging to the patient should be thoroughly disinfected before being worn again.

Whether the patient dies or recovers, the same precautions are to be taken with regard to the clothing and the apartment. The linen, bedclothing, and towels should not be sent to the wash until after they have been passed through such a solution as was used during the course of the disease. All such articles as carpets, curtains, etc., should be sent to the steam disinfection bath, and all other articles that cannot bear the temperature of the steam bath must be disinfected with spraying or antiseptic lotions. In localities where there are no steam disinfecting baths, sulphurous acid must be used. As small a room as possible is to be employed in this method of disinfection, and six hours is a sufficient length of time for the process. All articles disinfected in this manner should be exposed to the air for several hours before being used again.—*New York Med. Jour.*

The International Sanitary Convention came to an agreement last Wednesday, and if the provisions are carried out it will result in keeping cholera out of Europe and the United States.

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BALTIMORE, APRIL 7, 1894.

Editorial.

THE TREATMENT OF CHRONIC ALCOHOLISM BY HYPNOTIC SUGGESTION.

As the practical object of all treatment is cure, no means should be despised or neglected which will bring about this desired result. The danger of all so-called specifics, methods of cure and systems is that often harm results and the treatment is worse than the disease. When it is known that nine hundred million dollars are spent in one year in the United States on alcoholics, there is little wonder that physicians have cases of alcoholism to treat. Many of the plans of treatment are based upon the effect of the cure on the mind as much, if not more, than on the body.

Dr. G. E. Bushnell, of the U. S. Army (*Medical News*, March 31st, 1894) reports the results of treating twenty-three cases of alcoholism by hypnotic suggestion and while his success is not as brilliant as one might wish, still it shows that this method may have some chances of success if persisted in. Of these cases eight remained absistent, three relapsed and were absistent after further treatment, and the remaining twelve relapsed for various reasons. The cases were taken from the ranks of the army and were the worse possible kind, who were constantly exposed to further temptation. They came under hypnotic influence easily as a rule.

The treatment was given every day for a week and then once a week and later once a month. From three to six treatments removed the cravings for drink. Hypnotism as practised in this way did not seem to do harm to the patient and it was not exhausting; indeed, most of the cases seemed to feel refreshed on awaking.

Like all hypnotists, the writer of this article is more enthusiastic than the ordinary physician would be in treating such cases. This method of treatment is not new, but a few have given it a fair trial and there is no reason why it should not do good in some cases and it certainly deserves attention at the hands of the profession, even with the small number of cures as stated above.

APPENDICITIS OBLITERANS.

There is so much written on this disease at the present day, that the mere recitation of cases has little interest. Dr. N. Senn (*Journal of the American Medical Association*, March 24, 1894), thinks that appendicitis is an infective disease caused by pathogenic germs in the normal intestines finding their way into

the open appendix, which is like a test tube, and it is probable that the most common cause is the bacillus coli communis. In these cases there seemed to be an obliteration of the lumen of the appendix with retention of the contents, which by the lymphatics carry the infection to more distant points. In operating on such cases for removal of the appendix, he made an abdominal incision from a point half way between the anterior superior spinous process of the ilium and the umbilicus in a vertical direction down to near Poupart's ligament. The cecum was used as a guide; the mucous membrane of the stump was cauterized with pure carbolic acid, the stump dusted with iodoform and buried by deep sutures of fine silk. The rest of the operation is done as usual and the patient is kept in bed for four weeks or more and advised to wear a well-fitting bandage for six months afterward. His conclusions from his experience are:

1. Appendicitis obliterans is a comparatively frequent form of relapsing inflammation of the appendix vermiformis.

2. It is characterized by progressive obliteration of the lumen of the appendix, by the gradual disappearance of the epithelial lining and glandular tissue, and the production of granulation tissue from the submucous connective tissue, which by transformation into connective tissue and cicatrical contractions starves out remnants of glandular tissues, and finally results in obliteration.

3. The obliterating process manifests a progressive tendency, and may finally result in complete destruction of all glandular tissue and obliteration of the entire lumen.

4. The incipient pathological changes occur either in the mucous membrane of the appendix, in the form of superficial ulceration, or as an interstitial process following lymphatic infection.

5. The most constant symptoms which attend this form of appendicitis are relapsing acute exacerbations, short of duration, moderate or no appreciable swelling at the seat of disease and persistence of soreness and tenderness in the region of the appendix during the intermissions.

6. The process of obliteration may begin at the distal or proximal end, or at any place between, or it may commence simultaneously, or in succession at different points.

7. Obliteration on the proximal side gives rise to retention of septic material, which finds an outlet through the lymphatics, giving rise to non-suppurative lymphangitis and lymphadenitis.

8. Circumscribed plastic peritonitis is an almost constant concomitant of appendicitis obliterans, and hastens the process of obliteration.

9. Complete obliteration of the lumen of the appendix results in a spontaneous and permanent cure.

10. In view of the prolonged suffering incident to a spontaneous cure by progressive obliteration, and the possible dangers attending it, a radical operation is indicated, and should be resorted to as soon as a positive diagnosis can be made.

The City of Louisville, Ky., taxes each practising physician ten dollars.

The Governor has signed the bill providing for the better protection of men working in flint mills in Carroll County.

Correspondence.

ELECTROCUTION AND ITS FUTURE.

BALTIMORE, MARCH 26TH, 1894.

Editor Maryland Medical Journal:

In reply to your polite note of inquiry concerning the Electrocution Bill now before the Legislature of Maryland, I beg to say that in my judgment there will be no change in the present law and that the old barbarous mode of hanging will still be employed as a death penalty in this State. The proposed bill has excited very little attention and has not been urged by any body of citizens, nor has it met with any open opposition.

The *Baltimore American* is the only public journal that has taken any interest in the matter, but its very strong editorials have apparently not been headed by the wise men who make our laws at Annapolis.

Senator Moss, who introduced the bill, seemed to be of the opinion that the endorsement of the medical profession would avail much in securing its passage, and I, believing that there would be very great unanimity of sentiment in regard to the subject, introduced a resolution at the meetings of three of the medical societies of the city expressing approval of death by electricity in preference to hanging as a penalty for crime. In the Baltimore Medical Association the vote was unanimous for the resolution, though as might reasonably be supposed, the members are opposed to capital punishment. In the Society of the Woman's Medical College, the vote was also unanimous. In the Clinical Society, much to my surprise, some opposition was shown. Dr. Michael, who, slightly like Iago, is "nothing if not critical," vehemently opposed the resolution on the ground that the word "electrocution" is a barbarous compound and unworthy of a place in our language, overlooking the fact that it has appeared in our recent dictionaries and forgetting that the *usus loquendi* has ever ruled since the days of Horace. In his argument he contended that hanging was a much milder and more humane process; to use his own words, it was *cito, tuto et jucunde.* This statement was to me a little startling. Any one who has seen an execution or has read the sickening details of many that have taken place during the last few years will find difficulty in believing that hanging is a speedy, safe and pleasant mode of death. *Pleasant!* God save the mark! A poor unfortunate being writhing, quivering, struggling in mid air, at times breaking his thongs and vainly grasping his throat to end his agony, or again, the severing of the rope leading to a second tragedy is a spectacle that cannot well enter into the category of pleasant things. There were only four votes cast in the Clinical Society, three in the negative and my own in the affirmative, showing how little apparent interest the gentlemen took in the question.

The bill in my judgment will not be brought up for action at this session of the Legislature; but if capital punishment is still to be the penalty for crime, electricity in the future will be adopted not only by Maryland but by every other State as the mode of execution. Humanity, public decency and public moral-

ity demand this. Anæsthetics should be employed to lessen preparatory suffering, as the Jesus of old administered olibanum and wine for this purpose, but civilization is not yet far enough advanced for this humane procedure. Vengeance, retaliation, is still the feeling of the mass of men and not what the good of society really demands.

There is a bill before the Legislature of Ohio opposing hanging and providing that all murderers shall be put to death by means of anæsthetics, which are to be administered under the supervision of a board of medical men and scientists. The condemned man having been placed in a painless sleep, the scientists are to be permitted to remove the top of his skull, so as to watch the actions of the brain, and also to lay bare his heart and other organs so as to investigate the life process in them. This would appear to be going back to the vivisection of criminals allowed by the Italian government three or four centuries ago, and which was the only mode of studying anatomy permitted at that period.

However, the time is not distant when every form of capital punishment will be abolished. The best men of the age have condemned it. Lord Brougham, Basil Montague, Father Mathew, Judge Cooley, John Bright, Jeremy Bentham, Charles Sumner, Lafayette, Horace Greely and many other humanitarians have protested against it.

Men are even now devising humane methods for killing animals. In Berne, Switzerland, a scientist has found by experiment that it requires eight quarts of alcohol to kill an ox. In this instance Prof. Michael's axiom, *cito, tuto et jucunde*, would certainly apply. Yours truly,

JOHN MORRIS, M. D.

118 E. Franklin St.

Medical Progress.

MENTHOL IN SKIN DISEASES.

Since the connection of "dermographism" and urticaria with intestinal disorders has been recognized, more attention has been paid to the influence of intestinal disorders on the condition of the skin. According to recent investigations there are many cases of common acne where the patient shows a great excess of indican in the urine; but as soon as intestinal putrefaction is stopped by the internal administration of menthol in small doses (0.25 gramme), the skin eruption becomes, *pari passu*, markedly improved with the disappearance of the indican which ensues.—*Lancet.*

"DOC."

If it has been your misfortune to be called "doc," and if this recognition has become at all general among your friends you might as well move to some other place. A man may be called a thief, a liar and a dead beat, and yet he may prosper and live upon the fat of the land. But once let him be called "doc" and his professional success is at an end. We would prefer to spend a night in the station house, so far as its effect on our professional success is concerned, rather than to have our friends notice our approach by saying, "There comes doc." If a man calls you "doc" you need never expect a penny from him for any professional services you could render. His answer is sure to be, "All right, doc, in a few days that will be all right." "Doc" means disaster. "Doc" is the culmination of all calamity. "Doc" is a catastrophe given at one stroke. "Doc" is the warning that we have reached the extreme limit of our usefulness. "Doc" is the hand which points us to the next town. Shun it, my young friend, as you

would flee from a Kansas cyclone or a prairie-fire. Knock the man down who first dares speak it to you; and call upon the whole medical profession for vindication of your righteous deed.—*National Med. Review.*

A DEODORIZER OF IODOFORM.

In the *Norsk Magazin for Lægevidenskaben*, No. 3, 1893, the following formula is given as a deodorized iodoform:

Iodoform	gms. 197 (℥vj).
Carbolic acid . . .	gm. 1 (gtts. xv).
Peppermint oil . . .	gms. 2 (gtts. xxx).

SKIN GRAFTING IN LUPUS.

Lang presented to the Vienna Society of Dermatology a young man on whom he had operated for lupus of the face. The lupous tissue was excised through its whole extent, and the surface almost entirely covered by grafts taken from the thigh. A few days later the parts covered were completely healed, although the grafts were placed on a level some millimetres below the surrounding skin. There was no return in the case and, according to Lang, there need be none, if the incision is carried deeply enough.—*Jour. Cut. and Genito-Urinary Diseases.*

LIMITATIONS OF THE USE OF NITROGLYCERIN IN CHRONIC NEPHRITIS.

Dr. D. D. Stewart states that in his opinion, when it is desired to employ this drug over a considerable period of time for its effects on blood-pressure, the best rule of administration is to so proportion the dose that the intervals are comparatively short—never less than four times daily—and the amount, though sufficient to produce some subjective or objective effect, never more than that just necessary to cause the *slightest* feeling of fulness in the head or to slightly quicken the pulse. When a rather rapid increase seems necessary to maintain a constant effect, an equally important point is to temporarily discontinue the drug for two or more days, at intervals of two or three weeks. On its resumption a much smaller initial dose will be required to produce physiological effects than that last taken.—*The Therapeutic Gazette.*

GUAIACOL USED EXTERNALLY AS AN ANTIPYRETIC.

Dr. Wm. S. Thayer (*Medical News*, March 31st, 1894), having been tempted to try this new use of guaiacol from reading an account of DaCosta's experience, concludes from his eight cases in the Johns Hopkins Hospital that we are perhaps justified in asserting that guaiacol applied to the skin is readily absorbed into the economy; that its application is followed in most instances of fever by a gradual reduction in temperature, which reaches its lowest point generally between three and four hours after the application; that this fall of temperature is almost always associated with disagreeably profuse sweating; at a variable period, usually a short time after the lowest point is reached, the temperature rises rapidly, generally in association with marked chilly sensations, if not with an actual chill; that a dose of more than 2 cc. is rarely advisable; that exactly similar results are produced by the absorption of guaiacol through any other channel (the rectum, or the subcutaneous tissues); that the antipyretic action is exactly similar to that which has been previously observed to follow a corre-

sponding use of creosote and carbolic acid; that owing to the disagreeable effects of the immediate application of guaiacol (sweating and chilliness) and the weakening effects of the continued use, its employment as an antipyretic, as in the case of carbolic acid and creosote, will probably have but a limited application.

SURGEON'S HANDS.

One can tell, nowadays, something of the amount of work which a surgeon does and the thoroughness with which he does it, by looking at his hands. The strong bichloride and permanganate solutions with which the hands are sterilized (after the epithelium has been faithfully scrubbed off with a brush), make the hands rough and horny. The hands of some of the operators and nurses are practically incapacitated for work by this constant *régime.*—*Med. Rec.*

TO DISSOLVE A HYPODERMIC TABLET QUICKLY.

After the tablet has been introduced into the syringe containing ten or twelve minims of water, invert the syringe and drive out all air, then, placing the finger over the end of the syringe, withdraw the plunger. This creates a vacuum and the air in the tablet in trying to escape lifts the tablet to the top of the water, and bursts it to pieces. Try it, doctor, and you will save many shakes and give your patient more prompt relief.

PHENACETINE, A SAFE AND EFFICIENT ANTISEPTIC.

In a careful study of the coal tar derivatives Dr. Walton (*Medical Observer*) presents the following general estimate of phenacetine: "It is a popular remedy in migraine and forms of headache. As an anodyne we have often obtained the best results from it in maximum dose; and have found less than five grain doses in adults unsatisfactory. It is sometimes adulterated with acetanilide, which latter agent no doubt is responsible for what few untoward results have occurred from its use. Phenacetine is a useful substitute for antipyrine and acetanilide, especially in diseases of children. It has a similar field of application and is most generally used as an antipyretic and analgesic. It has been found of value in restraining delirium and inducing sleep, especially when due to alcoholic excesses. As may be inferred from its anodyne and antipyretic properties, phenacetine is an efficient agent in rheumatism and neuralgia, especially when combined with salol. It acts well in colds and influenza, and incipient malaria with general malaise and pains in the limbs and joints." The following is Dr. Walton's favorite formula:

℞.—Phenacetine, . . 1 drachm.
Pulv. Doveri, grains, xii.
Quininæ sulp., grains, xxiv.
Ft. capsul No. . . . xii.
Sig.—One every three or four hours.

This favorable verdict of the safety and efficiency of phenacetine contained in the above quotation is shared by the majority of practitioners, who have made conscientious trial of the remedy.—*Fort Wayne Med. Jour.*

FOR EPILEPSY.

℞.—Potassii bromidi . ʒiv.
Tincturæ belladonnæ . f ʒiij.
Infusi gentianæ compositus ad f ʒviij.
—M.
S.—A tablespoonful thrice daily.

℞.—Camphoræ monobromat, gr. xlviij.
Ext. gentianæ . . . . q. s.
Ft. massæ et div. in. pil. no. xij.
S.—One at bedtime.—Black, *British Med. Jour.*, No. 1723, p. 13.

Medical Items.

The daily press announces the death of Dr. Brown-Séquard, of Paris.

The Gynecean and Lying-In Hospital of Baltimore has been incorporated.

The Legislature has increased the pay of the police surgeons of Baltimore.

Dr. John Morris has resigned his position as President of the State Board of Health.

The British Medical Association will hold its sixty-second annual meeting at Bristol, July 31, August 1, 2, and 3, 1894.

The Medical and Chirurgical Faculty of the State of Maryland will open its ninety-sixth annual convention on April 24th, 1894.

Dr. J. B. Mullins, of Carroll, who has been so ill at the University Hospital, has returned home and is able to resume his work.

The bill granting the mayor and city council of Baltimore power to contract with a corporation to furnish a system of sewers for Baltimore failed to become a law at the Legislature.

The amended bill regulating the practice of medicine in Maryland passed both houses and will probably be signed by the Governor.

Mrs. S. H. Opie, wife of Dr. Thomas Opie, dean of the College of Physicians, died last week after a long illness.

The Fourth Annual Meeting of the Association of Military Surgeons of the United States will be held at Washington, D. C., May 1st, 2d and 3d, 1894.

The physicians of the United States now number 118,453; New York leads, with 11,171; Pennsylvania has 9,310, and Illinois ranks third with 8,002.

Dr. Lücke, Professor of Surgery in the University of Strassburg, and Dr. Julius Uffelmann, Professor of Hygiene in the University of Rostock, died recently.

At the commencement of the Medical Department of the Western Reserve University, held at Cleveland on March 28th, the degree of LL. D. was conferred on Dr. William H. Welch, of this city.

A committee consisting of Drs. Stowell, Bryan and Balloch has been appointed by the Medical Society of the District of Columbia, to consider what measures should be taken to prevent the ravages of tuberculosis.

The Medical Society of the State of Pennsylvania will meet at Gettysburg, May 15, 1894. Dr. E. E. Montgomery, 1715 Walnut Street, Philadelphia, is the chairman of the committee of arrangements.

Dr. John S. Billings has been elected an honorary member of the Royal Academy of Medicine of Belgium, and also a member of the International Statistical Institute, which has its headquarters in Rome.

The City Council has provided for free beds in the following hospitals: College of Physicians, 100; University of Maryland, 60; Baltimore University, 40; Good Samaritan, 20; Maryland General, 55; Maryland Homœopathic, 20; St. Joseph's, 30; St. Agnes', 30.

The death is announced of Dr. John H. Rauch, one of the most distinquished sanitarians in this country. For years he was President and Secretary of the Illinois State Board of Health, of which he was one of the founders; he also organized the first Board of Health of Chicago. He had always been an ardent advocate of higher medical education.

The Hospital Saturday and Sunday collections have been distributed as follows: Union Protestant Infirmary, $200; Church Home, $200; Presbyterian Hospital, $150; Baltimore Eye & Ear Dispensary, $75; Nursery and Child's Hospital, $203.60; Woman's Hospital, $125; Good Samaritan Hospital, $100; Free Lying-In Hospital, $75; Home for Incurables, $125; Cottage for Convalescents, $25; Hebrew Hospital, $100; Baltimore University Hospital, $25; University of Maryland Hospital, $100; Homœopathic Hospital, $50.

During 1893 the Berlin Medical Society held thirty-three meetings, at which thirty-seven papers were read and seventy-eight demonstrations were given. The membership of the Society is now 914. Its expenses for the year were 23,850, marks, its income 27,985 marks; its funds amount to 91,000 marks. The president for the current year is Professor Virchow, with Dr. Siegmund and Professor von Bergmann as Vice Presidents.

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Original Articles.

THE IMPORTANCE OF EARLY RECOGNITION AND TREATMENT OF OBSTRUCTIVE DISEASES OF THE UPPER RESPIRATORY TRACT.*

BY JOSEPH S GIBB, M. D.,

Instructor in Laryngology in the Philadelphia Polyclinic; Surgeon-in-Charge of the Ear, Nose, and Throat Department of the Episcopal Hospital, Philadelphia.

The introduction of a subject so time-worn and stale might require an apology were it not that notwithstanding there is a plethora of literature there still remains a singular indifference and lack of appreciation of the merits of the mat ter in the minds of the general practitioner. Doubtless much of this is due to the very voluminous character of the literature, which tends rather to interest those for whom the subject has an especial attraction. We read much of the histological structure of the various hypertrophies, and numerous are the instruments introduced for their destruction. We read less of the best means of demonstrating their existence, the etiological factors concerned in their production, and the prophylactic measures which may be adopted to prevent their development.

Perhaps no single abnormal condition is productive of more marked alterations in physical beauty and healthy functions than diseases producing obstruction in the upper respiratory tract. The anxious and watchful mother views with sorrow the freckling or tanning of her

*Read before the Philadelphia County Medical Society, March 14, 1894.

child's face. How much more disagreeable than these are alterations in the facial lines to such a degree as to cause a face to be expressionless; and when to this is added partial deafness, with all its unpleasant effects, we have a picture which any careful mother should strive to avoid. Were as much care bestowed on the important functions of the nasal chambers as is generally given to the skin or other tissues more directly under the eye, we would have fewer of these unpleasant pictures. Nor is this marring of physical beauty the sole deleterious result of these conditions; it can be proven that serious and perhaps grave interference with important functions follow in its wake.

In order to have a proper appreciation of the importance of the subject we will review for a moment, and in a cursory manner, the anatomical structure and physiological purposes of the nasal chambers and their contiguous structures.

The bony nasal chambers consist of three scroll-like bodies, the turbinate bones, two of which, the middle and inferior, are accessible in the living subject, which form the sides of the chamber. A septum, separating the nasal chambers, which is reinforced by a plate of cartilage in the recent state. These turbinated bones divide the nasal chambers into three meatuses—superior, middle, and inferior—into which open the various sinuses or foramina which communicate with the accessory cavities—namely, the frontal sinus, the ethmoid and sphenoid cells, the antrum of Highmore, and also the lacrymal duct. All these structures in the living subject are covered with mucous membrane well endowed with bloodvessels and nerves, whilst, over the turbinate bones, the tissue is erectile or cavernous.

The situation of these chambers, the peculiar construction of the bones, the unusually large surface of mucous membrane for so small a cavity, and the very generous blood-supply, bespeak important functions. Bosworth claims three: (1) the first and very important function in respiration; (2) an aid in phonation by acting as a resonant chamber; (3) as an olfactory organ.

The atmospheric air as it passes through the nasal chambers is brought in contact with a comparatively large surface of mucous membrane which is rendered warm by the free blood supply and moist from the secretion of the numerous mucous glands therein contained. The effect of this contact is first to abstract from the air-dust and other foreign bodies, and secondly to add to the inspired air warmth and moisture. This latter function is most important. It has been computed that over 7000 grains of water are expired from the lungs in twenty-four hours; and Aschenbrandt has demonstrated by a series of carefully conducted experiments that the source of this moisture is in the nasal chambers.

From this brief and very imperfect glance at the anatomical position and functional purposes of the nasal chambers we may draw a few important lessons. Interference with the proper and easy inspiration of air through the nasal chambers is productive of diseased conditions, not alone of those organs themselves, but of the more important respiratory structures within the chest.

It cannot be doubted that inspiration

of air into the air vesicles imperfectly warmed, deprived of the moisture which Nature intended it should have, must exercise a deleterious influence on the delicate mucous membrane lining these cells. I am not ready with statistics to prove the relationship between pulmonary and bronchial affections and obstructive diseases of the upper air tract, nor do I deem it necessary, for it is a matter of common experience and observation that those children whose nasal chambers are obstructed either directly by hypertrophies, polyps, etc., or indirectly by hypertrophied pharyngeal or faucial tonsils, are sunken-chested, prone to attacks of acute bronchitis and coryza, and in many respects are less healthy than other children. I am well aware that these conditions are often the result of a constitutional vice which in itself renders the subject less robust, still I am more than ever convinced that removal of the local effects of this diathetic condition results more effectually in a return to a normal condition than any plan of treatment directed solely to the condition itself. Nor is it alone the respiratory tract that suffers from these abnormal states. I have before remarked that children so afflicted are apt to be in a condition of poor health generally, and it has occurred to me that perhaps this may be not entirely due to the diathetic condition which is so frequent a concomitant, but rather that the lungs, being supplied constantly with a vitiated air, *i. e.*, air insufficiently warmed and moistened, failed to supply the blood with a healthy, proper pabulum and hence the tissues suffer. Be the explanation what it may, we must not lose sight of the fact that a condition of ill health frequently does exist and we should bend our energies to ascertain the cause and seek its remedy.

It is not the object of this paper to elaborate on the various methods of treatment, but rather to inquire into the causation and to endeavor to point out means which may be taken to ameliorate the conditions existing and to prevent the development of more serious ones. Especially is it desired to inquire into the causative influences of obstructive diseases of the upper air-passages in young children.

Eliminating all those effects of imperfect or perverse fœtal development such as occlusion of anterior or posterior nares, cleft palate, etc., we have conspicuously prominent in the category of obstructive lesions in the upper respiratory tract—hypertrophic conditions of the turbinate bodies, of the pharyngeal, faucial, and to a lesser degree the lingual tonsil.

A glance at the records of any of our large throat and nose clinics will convince one that these abnormal conditions are far from rare; nor does even this showing give us a thoroughly accurate conception of their frequency. Too common is it to ignore or carelessly treat the various catarrhal symptoms presented to us, and this indifference on the part of the profession has led to a corresponding indifference on the part of the laity, so that only those cases of pronounced obstruction are brought to the notice of the general practitioner. Were the nasal speculum used as freely as the stethoscope or clinical thermometer we would be astonished at the result. Again, certain hypertrophic conditions have but comparatively recently received any

measure of attention from the profession. Though faucial hypertrophies have been observed and studied from remote times, it was not until a very recent date that Meyer gave to the profession a clear idea of the significance of hypertrophic conditions of that collection of adenoid tissue at the vault of the pharynx known as the pharyngeal tonsil; nor is the importance of the subject to-day appreciated by the rank and file of the profession, nowithstanding that much has been written about it and many instruments devised for its removal. Situated as it is in a somewhat inaccessible or rather unobservable portion of the upper pharynx, it is only by the use of the rhinoscopic mirror that its presence can be clearly demonstrated; this being the case, it is patent that it must be frequently overlooked.

With these facts before us it is clear that, whereas our clinics show us that these states are common, they give us no adequate conception of their prevalence.

At the clinic of the Episcopal Hospital it is the custom to carefully examine the nasal cavity, the pharynx, and post-nasal surfaces in every case that applies for treatment, irrespective of the fact that the subjective symptoms point to lesions in this or that locality; and in children of tender age, where a rhinoscopic examination is not feasible, if there is any suggestion of disease in this locality a finger is introduced back of the soft palate and over the vault of the pharynx to demonstrate by tactile sense the presence or absence of any abnormality. . It is surprising as a result of this procedure to note the number of cases in which there are lesions of the upper pharynx in which the symptoms have been overlooked by the parents.

In considering the etiology of these hypertrophies it is as well to treat of them collectively, for whereas they are often separate and distinct lesions and exist independently, they are often associated and their etiology, so far as our knowledge goes, is in many respects similar.

In the case of the glandular tissue there can be no doubt that in a few instances these hypertrophies are congenital; doubtless the effects of an inherited vice—syphilis or scrofula—carrying out the well-known tendency of these dyscrasiæ to affect lymphatic and glandular tissue. Though this view is combated by no less an authority than Meyer, who leans to the view that it is always an inflammatory process in a tissue which normally is largely developed in infancy and childhood, at the same time it is difficult to explain the presence of this state in very young infants unless we presume this inflammatory process to have taken place during its pre-natal existence. Those cases developing subsequent to birth doubtless have as a starting-point an inflammatory or catarrhal origin.

We have demonstrated the frequency of hypertrophies of the glandular tissues and turbinates in children, and have admitted a few cases may be congenital, which leaves the vast majority to have its development subsequent to birth; and, as it is our belief that its causation lies in some condition outside of the child, at least in part, it is now our endeavor to seek out those causes and, if possible, lay down certain laws looking to their eradication or, at least, ameli-

oration. Here, as with many other diseases of insidious approach, an early recognition is productive of much good.

Among the general causative agencies which it is not entirely within our power to relieve, may be mentioned atmospheric conditions incident to residence in temperate climes, and especially near the seaboard; the method of heating houses in cities by dry air frequently derived from an unsanitary source; carelessness in the dressing of infants and trusting them too much to the care of servants who unnecessarily expose them. All these and others exercise an influence in the production of the disease, but only in a general way. The prophylactic remedies are obvious and suggest themselves.

The various catarrhal conditions which the above enumerated disturbing influences of our environment occasion are of much importance from an etiological standpoint. There can be no doubt that it is here we have the starting-point of the hypertrophic process. A simple coryza is neglected; the child is not even protected from the causes which produced it—the result, one coryza succeeding another the entire season. The effect of a long-continued inflammatory process is precisely the same in the nasal and pharyngeal tissues as in the other tissues of the body—namely, increase in the connective-tissue growth, increase in the cellular growth. And it is just here by a knowledge of the effects that the family physician's advice and council can be of so much value and save so much misery and suffering to the child—so much mental anxiety and mortification to the parents. I believe that parents should be taught that a coryza is by no means so simple or harmless an affair as is commonly believed. It is better to err on the right side—better by far to give some attention (possibly needless) to a few attacks of coryza than to sit quietly by doing nothing and permitting the production of obstructive masses in the upper air-passages that may alter the child's expression and possibly injure the health.

Parents should further be taught that repeated coryzas indicate a diseased condition of the nasal or pharyngeal mucous membrane demanding prompt and thorough treatment. The physician should himself insist on making a careful examination aided by the nasal speculum and rhinoscopic mirror, and should lay down a plan of treatment which his ingenuity will suggest, and persevere with it until the conditions yield; and I believe in this way, and in this way alone, can we hope to have any measure of success.

Conspicuous in the category of special causative agencies may be mentioned the eruptive diseases of childhood, and especially those in which the fauces and nasal chambers are involved in the diseased process. Foremost among these may be mentioned diphtheria. The well-known tendency of diphtheritic processes to attack glandular tissue is well exemplified in the post-nasal spaces. We are familiar with the appearance of the diphtheritic membrane on the tonsils, but usually the examination of the other mucous surfaces is not made, and we remain in ignorance as to the extent of this process into the nasal chambers and vault of pharynx. Doubtless if careful examination was carried out in every case we would find the proportion in

which these structures are involved to be very large. I have no doubt that many of the cases of so-called reinfection are in reality those in which there has been an involvement of the pharyngeal tonsil in the diphtheritic process. When an examination of the tonsils reveals an absence of the familiar membrane and a subsidence of the inflammatory condition, we are lulled into a sense of security and perhaps relax in our vigilance unmindful of the fact that the disease is perhaps making insidious inroads at a spot beyond our unaided view. However, we are not concerned with this at present; sufficient is it for us to know the extreme susceptibility of the mucous surfaces in this disease.

After the subsidence of the diphtheritic process it is very common to have a catarrhal condition continuing for a considerable period; this is especially noticeable in cases in which the nasal mucous membrane has been implicated; though it frequently occurs where there has been no perceptible involvement of the nasal chambers, and I believe it is just in these cases that there has been a diseased process going on at the vault of pharynx. The explanation of this mucous discharge and other evidences of a catarrhal condition is doubtless due to alterations in the nutrition of the part, in consequence of the high grade of imflammatory action, and also to septic absorption. Were an examination made at this time we would likely find a hypertrophic condition either in the nasal turbinates or the pharyngeal and faucial tonsil. Though doubtless the majority of these cases do well without any special treatment directed to the part, yet in a certain number the catarrhal condition persists, and especially is this likely to occur in those children who seem prone to catarrhal states, and the foundation is laid for the formation of masses of hypertrophied tissue.

The beneficent offices of the family physician can be here admirably employed. It is not wise to pass over lightly the persistence of a catarrhal state after the subsidence of the imflammatory symptoms. Treatment employed at this time and persisted in until an amelioration takes place can be productive only of good.

Scarlatina, as is well-known, expends at least a part of its energy on the mucous membrane of the fauces; though, unlike diphtheria, rarely involves the nasal chambers. Here, as in the foregoing, the inflammatory action is so high, often to the production of false membrane, as to exercise a baneful influence upon the nutrition of the tissue and aid in the production of hypertrophies. We are all familiar with the fact that hypertrophies of the faucial tonsils are a frequent sequela of this disease. The same process that gives rise to hypertrophies in this tissue is at the same time exerting its influence on the tissues of the vault.

It is needless to dwell on this; the too familiar sight of catarrhal conditions as sequelæ of scarlatina precludes any argument to the contrary as to its position as a causative agent in the conditions under consideration. Nor is it hardly necessary to refer to the necessity for prompt treatment—one word, however, on this point. It seems to me an imperative duty on the part of the medical attendant to insist on an examination, and if necessary subsequent treatment in every case where a catarrhal condition evi-

denced by a mucous or muco-purulent discharge from the nose, a thick voice, and mouth-breathing persist, after all evidences of the exanthemata have passed away.

Measles, though commonly regarded as a light and insignificant disease, is exceedingly apt to leave some trace of its existence. The explanation of this is evident. Not commonly menacing life, it is, however, very active in its attack, and this activity is exerted on the mucous surfaces in the entire respiratory tract. Mothers should be informed of the fact that with care the course of the disease will be benign, but without it there is extreme probability of a catarrhal affection with all its unpleasant consequences being left as a sequela. And here, as with others, active treatment should be insisted upon if the catarrhal symptoms persist after the subsidence of other evidences of the exanthemata.

The other exanthemata and febrile diseases, such as rötheln, variola, varicella, typhoid fever, etc., exert a certain amount of influence as causative agents, but only in a general way, as any alteration in health will do. The diseases mentioned, viz., diphtheria, scarlatina, measles, exert a special influence because the diseased condition seems to expend itself on the mucous surfaces, producing alterations and perversion of function.

The clinical picture presented by sufferers from obstructive diseases of the upper respiratory tract is absolutely characteristic, and especially is this true as regards the alteration of facial lines and changes in expression. Naturally this obstruction to the entrance of air by the normal route, viz., through the nose, necessitates its seeking some other mode of ingress to reach the lungs; the only other way is through the mouth, and hence we have the condition of mouth-breathing with all the discomfort and unpleasant effects which such a condition entails. Long continued mouth-breathing brings into play muscles about this orifice not usually called upon for excessive work, and at the same time nominally puts at rest muscles about the nose whose functions are not called into play; the result is an alteration of facial expression to such a degree in well-marked cases as to give to the child a stupid, almost idiotic appearance. The obstruction in the case of the pharyngeal tonsil may become so excessive as to encroach on the pharyngeal orifice of the Eustachian tube, interfering with the proper supply of air to the tympanic cavity, thus inducing catharrhal or inflammatory conditions of the mucous lining of this tube and also of the tympanic chamber. The result of this is dulness of hearing or even complete deafness.

The normal course of the secretion from the numerous mucous glands in the nasal chambers is obstructed and hence flows back into the naso-pharynx; added to this we have a greatly increased secretion from the adenoid vegetation at the vault. During sleep this mucus collects in the pharynx, and as the child is obliged to breathe through the mouth, we have associated loud snoring with rattling and gurgling of air through the mucous secretion; hence the sleep of the child is restless and fitful and the annoyance to other members of the household excessive.

We have then as the salient features of a case we are attempting to portray: mouth-breathing, snoring, rattling of

mucus in the fauces, and disturbed sleep; a dull, listless expression of countenance; hardness of hearing, and in many cases impairment of general health, causing the child to be anæmic, sunken chested, prone to catarrhal attacks, and of stunted growth.

Much has been written and various are the opinions as to the treatment of these distressing conditions. We are not concerned in this article whether it is the proper method to remove adenoid growths by forceps, curette, or finger; to diminish hypertrophied turbinates by means of galvano-cautery snare or escharotics; but a few words in conclusion as to the management of cases in their incipiency may not be amiss.

Mothers should be urged not to neglect a persistent snuffle in her child, to regard as trivial the continuance of a mucous discharge after diphtheria or the exanthemata. Physicians, on the other hand, should not pass these complaints lightly by ignoring them or directing in an indifferent manner some simple and likely inefficient remedy.

The management of hypertrophies at this early stage is as simple as the results are happy. After a careful examination the nares and upper pharynx should be cleansed of mucus by an antiseptic and detergent spray, *e. g.*, Dobell's solution, Seiler's tablet, Listerine in diluted solution, etc., and then applications made to the affected mucous membrane of an astringent or alterant, depending on the conditions of the parts. Should we find simply an increased secretion with no appreciable alteration in the turbinates, tonsils, and surrounding tissues, it is likely we will accomplish all that could be desired by directing spraying of the nares thoroughly by one or other of the solutions mentioned twice daily and continued faithfully until the membrane presents a normal appearance and the secretion ceases.

In cases still further advanced in which we find the turbinates quite red and somewhat swollen; the pharyngeal tonsil secreting more mucus than normal and rather large; the faucial tonsil red and somewhat hypertrophied, we will find it advantageous to use some application to diminish the inflammatory condition. These applications may be made quite painless by spraying the parts with a 5 per cent. solution of cocaine or introducing a cotton tampon saturated in the same solution. In the nares a solution which has gained favor in the various clinics devoted to these diseases is that of iodine. The strength of the solution may be graded by the severity or obstinacy of the case. It is well to begin with a weak solution, increasing the strength as the necessities of the case demand. In some cases which resist this plan of treatment a touch of the fused bead of chromic acid along the turbinates will often accomplish the desired object; this latter plan should be immediately followed by the antiseptic spray to dilute and limit the destructive power of the escharotic. It is merely necessary in these early cases to touch the mucous membrane lightly to produce a superficial eschar; the resulting slough and subsequent contraction will so squeeze the bloodvessels as to bring about the desired diminution in the size of the tissues.

The pharyngeal tonsil also in many cases will respond satisfactorily to application of the iodine on a pledget of cotton

carried by an applicator so curved as to pass readily behind the soft palate and up to the vault. Glycerole of tannin has been found to act very happily, though perhaps a little more unpleasant in its effects. The application of chromic acid (fused) to a pharyngeal tonsil should not be advised, though undoubtedly as useful as in the nose, unless the operator is steady and familiar with making applications by the aid of the rhinoscopic mirror.

It would be hardly necessary to refer to the treatment of catarrhal and slight hypertrophic conditions of the faucial tonsils the result of the causes named, were it not that here, in spite of the ready accessibility of the part, they are subject to neglect. The same process of cleansing is as necessary as in the other hypertrophies, after which an application of a solution of 60 gr. to the drachm of nitrate of silver, glycerole of tannin, or in stubborn cases producing a superficial slough by fused chromic acid, will probably answer every purpose.

In the more advanced cases or in those which fail to respond to the above-outlined plan of treatment and a steady increase of the hypertrophied tissues occurs, there is but one plan which should be carried out at as early a date as possible, namely, a destruction of the hypertrophied tissue. The various plans to accomplish this object will not be touched upon, but can be readily learned by consulting any of the modern treatises devoted to the treatment of diseases of the nose and throat.

In recapitulation, the object of this paper has been to call attention to the following points:

1. The importance and desirability of early attention to diseases of the upper respiratory tract consisting of the nose and naso-pharynx.

2. The production of alteration in nutrition and possibly pulmonary and bronchial troubles by hypertrophic conditions of the upper respiratory tract.

3. The etiology of these states referring to the influence of environment and especial mention of diphtheria and the exanthemata as prominent factors in this category.

4. The prevalence of these conditions.

5. Carelessness and indifference in both physician and patient as to the various catarrhal states which are believed to be the precursors of the diseases under consideration.

6. The necessity of early treatment and the power for good exercised by the family physician in these troublesome conditions.

7. The clinical picture presented by these unfortunates, laying especial stress on the alteration in the facial expression and the distressing and annoying condition of the child during sleep.

The series of lectures by Dr. Wm. Osler on the Diagnosis of Abdominal Tumors, in the *New York Medical Journal*, have been concluded and will be republished in one volume.

Of fifteen physicians examined by the Maryland State Board, Dr. Ida Pollock stood the highest.

Dr. O. S. Mahon, of North Exeter Street, and a graduate of the University of Pennsylvania, died last week, in his sixty-ninth year.

A REPORT OF EIGHT CRANIOTOMIES; WITH REMARKS ON THE TREATMENT OF LABOR IN CONTRACTED PELVES.*

BY DANIEL LONGAKER, M. D.,
OF PHILADELPHIA.

When labor is rendered pathological by the existence of contraction of the pelvis, certain deviations from the normal occur which it may be well for us to glance at here. These have reference to the fœtus and to the process of dilatation. Normally the head rests in the pelvis before a single pain occurs, even in a multiparous patient and in a primiparous weeks before the advent of labor partial descent and partial flexion will have taken place. In the latter the absence of this adaptation on the approach of labor is significant of disproportion between the presenting part of the child and the pelvis, and either the head is not in relation with the pelvic inlet or it is too large.

So long as engagement has not taken place even the experienced may be in doubt of the nature of the presenting part on mere digital examination. Too much emphasis cannot be placed upon this one point. A pelvis relatively empty and the presenting part reached with difficulty by the examining finger means, very frequently, the existence of narrowing. This is true even if found very early in labor and in a primipara before labor. All such cases demand the fullest investigation. If the attendant is not competent to make a careful estimate of the degree of pelvic narrowing, and finds this suspicious sign of its existence, he should request expert aid without delay. It will not do to leave such a case to chance. It is inexcusable to conclude, that since the pains are infrequent and the os is undilated nothing can be done, and therefore the doctor may go home to finish his peaceful slumbers or to attend to his usual routine of calls.

The dilatation of the os is slow and the pains are irregular. A bag of amniotic fluid may be forced down, distending even the perineum, but when it has ruptured dilatation will be found incomplete. The os is undilated and remains *undilated.* As a rule, however, it does not long remain undilatable. All that is required to secure dilatation is advancement of the presenting part.

The general management of this class of pathological labor may next be considered. Unless clear ideas upon the subject of treatment are generally diffused, it will certainly be a long time before craniotomy becomes an obsolete operation. Time was when it was more frequently done than the forceps operation. The time will come when even its present relative infrequency will no longer be known, and to aid in bringing this about is the chief object of the present contribution.

If the obstetrician has not informed himself fully of the relation of the child to the pelvis and of the conformation of the latter before the advent of labor, no time should be lost in doing so as soon as he sees the case. External examination, either alone or combined with internal, will disclose the exact relation of the fœtus to the parturient canal. The rectum and the bladder must be empty.

*Read before the Philadelphia County Medical Society, March 14, 1894.

Much can be learned by external examination of the size of the fœtus and of the extent of the disproportion between the head and the pelvis. Ether should be given if necessary. Relaxation of the abdominal parietes is thus secured. The hand may also be passed into the vagina, although I have not often found this requisite. The position, rate, and intensity of the fœtal heart-sounds should be noted early. Pelvimetry will afford valuable data, and it should never be omitted. I refer to instrumental and external measurements, having no experience with the recent instruments for taking the internal diameters. It must be admitted that there is a need for such, and I believe the instruments of Skutch, Hirst and others will fill a real want.

I know of no method to differentiate between a generally contracted pelvis and a flat one other than this, and a knowledge of this fact is of the greatest practical importance. Thus a conjugate of three and a half inches, with ample transverse diameters, is a trifling affair alongside of the same conjugate with a proportionate shortening of the transverse diameters. In the latter the mechanism of labor is totally different, the treatment may differ and the prognosis is much graver. But, fortunately, the flat pelvis is the type we usually meet with. In this list it existed in all save one, or, at most, two cases. In estimating the conjugate I have limited myself to the digital method. One or two fingers are introduced into the vagina, at the same time depressing the perineum; the finger or fingers are directed upward until the round sacral promontory is reached. The other hand separates the labia, and with the index finger the point of the subpubic ligament is marked. The distance from this point to the tip of the finger resting upon the sacro-lumbar articulation is the diagonal conjugate. I believe a deduction of three-quarters of an inch from this will give an approximate measurement of the true conjugate in most cases. I am convinced the true measurement will be underestimated more frequently than overestimated by this plan. In a true conjugate under three and a quarter inches no difficulty will be experienced in reaching the promontory with the index alone.

As to the difference in mechanism. In the generally contracted pelvis the head enters, if at all, in a state of extreme flexion. In the flat, between flexion and extension, both anterior and posterior fontanelle on about the same plan. The bi-parietal diameter adjusts itself to the so-called lateral conjugate—the line from the symphysis to the hollow of the sacral wing—and the bi-temporal diameter is in relation with the true anterior posterior diameter of the pelvis. Thus the jutting promontory of the sacrum may be passed by a head of moderate size, since the bi-temporal diameter is rarely much above three inches, and half an inch less than the bi-parietal. In addition, the head tends to enter the pelvis and pass the obstruction in a position of lateral obliquity, the sagittal suture nearer to the promontory than to the symphysis. This peculiar mechanism is sometimes spoken of as the cause of dystocia. I have even known of attempts to force the lateral occiput to the front under this mistaken impression. It is needless to say this should not be done.

The membranes should be carefully protected; early rupture is to be avoided. If anterior obliquity of the uterus exists the patient should be placed on her back and a bandage should be firmly and evenly applied. Nothing answers better than a stout piece of muslin wide enough to extend from below the trochanters up to a level with or a little above the fundus uteri. This the obstetrician himself secures firmly by means of large safety-pins. When properly and early done, I am sure many a case of malpresentation and serious dystocia may be prevented.

The risk of infection should not be increased by repeated digital examination. After the peculiar features of the case have been learned, they are unnecessary, can do no good, and may do harm. A period of judicious expectancy is quite proper, and if the contraction is not too great and the fœtal head of average size or under, the maternal efforts may overcome the disproportion. I have seen this more than once where the conjugate has been under three and a half inches. During this time all possible means are employed to preserve the patient's strength. Easily assimilable food is to be taken, and a moderate dose of opium is often of advantage. During the expulsive stage quinine sulphate in a single fifteen grain dose, strong coffee, and, occasionally, alcoholic stimulants are appropriate. Encouragement and sympathy are to be extended to the patient. From time to time the fœtal heart-sounds are noted. As soon as it is evident that the woman's unaided efforts are insufficient and before the child's life is endangered, delivery must be assisted. I am convinced that the use of the forceps, and especially of the axis-traction forceps, is proper. Applied at the right time and in a proper way an average sized head may be delivered when the conjugate is three and a quarter inches. In a paper published in the *American Journal of Obstetrics*, May, 1877, I report several successful cases where the contraction was even greater. I would prefer the forceps to version because failure to deliver does not involve sacrifice of the child's life. If any doubt exists of the possibility of speedily extracting the after-coming head, version should not be done. To resort to version after the forceps have failed seems illogical, since there must be greater uncertainty of being able to deliver the after-coming head quickly after a decided disproportion has been thus demonstrated. Besides this there is considerable danger of rupture of the uterus when the operation is undertaken after the waters have been drained away and when it is contracted on the fœtus. To make version and then allow the child to die in order that we may not be compelled to perforate a living child's head seems to me equally wrong. Nor do I believe that craniotomy is rendered easier when the head is last. My own view is that with forceps at the proper time, just as great a degree of disproportion, if not a greater, may be overcome and with less risk to either mother or child than with version. I would not choose the latter operation unless I was sure the head could be quickly extracted.

None of the details of an aseptic major surgical operation should be omitted.

As such, the application of the forceps at the superior strait is to be regarded. Undue force is not to be used.

It will render the result, so far as the child is concerned, as bad as craniotomy, and for the mother worse.

I think it no exaggeration to say in advance that the management of the following cases offers a marked contrast to the plan just sketched. And yet the case is but a counterpart of all the rest, with little variation in unimportant details. Its history is given without further comment.

Case VII.—In the latter part of April, 1893, I was asked to see Mrs. S., a native of Poland, who was then living at the rear end of a court not far from my residence. In this, her fourth labor, she had first the services of a midwife, who concluded, after very active labor had existed over three hours, that a physician ought to be summoned. She told me she had only given 5j of the fluid extract of ergot, and that in spite of very severe expulsive pains, no advance whatever had been made in the position of the head. The doctor, a regular practitioner and a man of some obstetric experience, attempted to apply the forceps, but failed, and at the end of an hour decided to call on a friend and neighbor, also a well qualified practitioner—one who had served a term as interne in one of our largest hospitals. Together they succeeded in getting the instrument on the head, but ordinary traction efforts failed to advance it. Finally, bracing the feet against the edge of the bed, the forceps slipped and the operator landed against the wall. At 12, midnight, it was concluded that forceps could not deliver the child. This was *eleven* hours after the membranes had ruptured, and during all this time the woman had been in very active labor, which had now been in progress about twenty-four hours. However, podalic version was made, but now the real difficulty seemed to begin, and all the power two strong men could bring to bear on the delivered body failed to extract the head. Efforts at extraction were continued until the vertebral column parted and the body was torn from the head. At this juncture it was decided that the head could not be delivered unless it was first crushed, and this I was asked to do by the physician first summoned. Arriving at the house I found doctor number two had abandoned the case, the midwife alone in attendance. The remarkable advice had been given to summon an ambulance and send the woman to the Philadelphia Hospital, three miles away. The woman was then having short, rapidly succeeding pains, the uterus in tetanic contraction. Her appearance was extremely anxious, pulse frequent, and temperature above normal. The body of a very large male child lay on the bed between the thighs. The vulva was œdematous, the labiæ minora being swollen to the size of one's flattened hand. There was an offensive odor of decomposition. The head was in the uterus above the plane of the pelvic inlet and attached to the body by integument only.

After irrigating external genitalia and vagina, a catheter, introduced into the bladder with great difficulty, withdrew a few ounces of urine. The entire vagina was greatly swollen, and that there was no sloughing afterward was a matter of surprise to me. The left hand introduced into the uterus found the face looking to the right, an ear just above and behind the symphysis. The midwife held the child's body up out of the

way; the physician in attendance steadied the head through the abdominal wall, and thus perforation by means of the Blot perforator was quickly made. This is a straight instrument. The brain was broken up thoroughly by passing the point of the instrument all around in the cranial cavity. Without flushing this, the Braun cranioclast was quickly adjusted, the head collapsed, the opening being near the base of the cranium, and the entire operation was concluded in less than ten minutes. As the head escaped its resiliency caused air to be sucked into the perforation, and the sound emitted was something similar to that observed during the first inspiratory effort of a half-drowned baby. Mistaking it for this, one of the assistants exclaimed, "And can it be possible!"

The placenta was quickly expressed, the uterus irrigated with a large amount of hot water, then with a 1:2000 bichloride of mercury solution followed by more hot water. The child was a male and weighed over nine pounds minus blood and brains. The diagonal conjugate measured after delivery was exactly four inches. A liberal estimate would give three and a quarter inches for the true, the conjugata vera (8.2 cm.). The brief details of this woman's parturient history which I learned after the delivery was completed may not be uninteresting.

Her first labor was long and difficult, and the baby, though small, was born dead. I could not find out whether instrumentally or not.

In her second pregnancy premature labor occurred at the end of the seventh month as the result of a fall, and twins were born, the first one living a few days and the second seven months.

In the third labor the baby also perished; she was septically infected and sick in bed two months.

At 10 A. M. on the day following labor there was a normal temperature, and pulse 96. In about two weeks she was up and about, and I believe made a perperfect recovery.

I have given the history of this case in full because it is fairly representative save in a few unimportant particulars. For this reason a more detailed account of the other cases is omitted.

All were seen in consultation, the writer being called after labor had existed many hours, and, as a rule, when one plan of treatment after another had failed to effect delivery. Various oxytocics, including ergot, had been given; forceps of various designs had been applied, and failing, version had been attempted, with what success is seen in the case just detailed. It is needless to say the child's life had ceased in nearly every case. In spite even of a parturient history, that would of itself be suggestive of pelvic deformity, this was rarely suspected. Nor did the peculiar mechanism and course of the labor at once impress themselves upon the minds of the attendants.

The contraction in none of the cases save the first was very great. The labors were insuperably obstructed by the large size of the children.

In cases IV., V., and VIII. the greatest difficulty was met with in the extraction of the body, and this was accomplished finally by perforating the thorax, applying the cranioclast, and completing the delivery by traction on this. I am sure it would otherwise have been impossible.

And yet case IV. has given birth to a living child since the craniotomy, without any special difficulty.

A word in regard to cases I. and V. The first should never have been delivered by craniotomy. An early Cæsarean section would have saved the child and given the mother a chance. When the conjugate approximates two and a half inches (0.063 m.) the difficulty to be anticipated in extracting an eight-pound child is not small. The fact that conjugate narrowing to this degree is, as a rule, associated with transverse shortening is not to be forgotten.

This was the only fatal case.

Case V., seen with Drs. De Young and Leopold, is in some respects the most unique of the entire group. Lying across the bed she was truly a mountain of flesh; her weight must have been between three and four hundred pounds. The mere making of a digital examination was exhausting. The skin covering the abdominal parietes was as hard as parchment. Subcutaneous tissues and muscles were waterlogged and infiltrated with fat. It was one of the rare instances in which abdominal palpation would be impracticable. The amniotic fluid was in excess. There was early prolapse of the cord. The attendants had utterly exhausted themselves in their efforts to advance the head, and failing, had attempted version. Although the head was still very high and hard to reach from below, no special difficulty was experienced in the perforation. The extraction was difficult, however, because of the enormous size of the child. I regret that it was not weighed. The woman made a rapid recovery. Attempts to learn of her subsequent history and condition have not been successful. Fancy to yourselves either an abdominal delivery or a symphysiotomy through such tissues!

In conclusion, I want to emphasize the following points:

Insuperable obstruction of labor because of pelvic contraction is a frequent condition.

Arrest of the head at or above the pelvic brim is comparatively easy of recognition by attention to the details of external palpation, by the combined method and by the peculiar course of the labor.

Disproportion between the head and pelvis ought always to be recognized early in order that correct principles of treatment may be adopted.

Forceps may be employed when, after a period of judicious waiting, it is evident that the natural powers unaided are incapable of driving the head beyond the obstruction. Their use must be attended with all the care usually observed in the execution of a major surgical operation. If the disproportion is evidently very marked, leading to doubt of their successful use, an alternative should be decided on at the outset in the event of their failure. This will obviate the needless loss of valuable time.

Podalic version may be made where the membranes have not been long ruptured, and when the operator is reasonably sure of encountering no great difficulty in the extraction of the after-coming head. It is of doubtful expediency after the forceps have been applied unsuccessfully.

An experience of two symphysiotomies goes far towards convincing me that this operation is destined to take high

rank in the list of life-saving obstetric procedures; that it is *the alternative* when, in a contracted pelvis of moderate degree (not under 6.7 c. m.), the obstruction cannot be overcome by other means, and that it will go a long way in the direction of rendering the horrible operation of craniotomy obsolete and the Cæsarean section under the relative indication unnecessary.

Society Reports.

MEDICAL SOCIETY OF THE UNIVERSITY OF MARYLAND.

STATED MEETING HELD TUESDAY, MARCH 6TH, 1894.

Dr. Charles W. Mitchell in the chair, Dr. William B. Canfield, Secretary.

Dr. F. T. Miles, in referring to a paper that was read at the last meeting, asked if the stomach could vomit its own contents, or did it require the abdominal muscles. In this case the man's abdominal muscles were flaccid and yet he suffered greatly from nausea and vomiting, which would show that there is an expulsive force in the stomach itself. He related the experiment of putting a pig's stomach in a dog and the vomiting that resulted. This kind of vomiting may be observed in yellow fever, the vomit being sent to considerable distances.

Dr. Randolph Winslow referred to a similar case in which a distended bladder caused nausea and vomiting.

Dr. Randolph Winslow then exhibited "A Case of Gun-Shot Wound of the Bowel; Entire Recovery; Exhibition of the Patient."

He was a man over sixty, who had been shot early in the morning and was brought into hospital a few hours later. He was a spare but healthy man and did not seem to be suffering. An incision was made in the right iliac region just over Poupart's ligament, through the wound. There was blood in the abdominal cavity. Four wounds were found in the intestine, all in the ileum; three were close together and the fourth was eight to twelve inches distant. This was quite large and looked as if a piece of tissue had been plowed out, and it required ten to twelve sutures to close it, while the smaller ones were closed with four to six sutures. The temperature remained about 100° the first week and then rose and fell a few days and then, some pulsation being noticed, the right iliac branch was cut down on and tied and some clots were removed from the abdomen and finally the wounds all healed and the patient recovered. His milk diet caused some constipation, but now he has a passage every day and is growing stout. This is the first case of its kind to recover as far as he knows.

Dr. Charles W. Mitchell then exhibited a "Case of Thoracic Aneurism." It was in a colored man of about 35 or 40, of low intelligence, giving a very meagre family history. He probably had a specific sore on his penis about fifteen years ago; was married eight years ago and had one child, since dead. He came into hospital not long ago and an examination showed an aneurism of the descending portion of the aorta with erosion of the ribs and scapula behind and the appearance of a large pulsating tumor, which made the diagnosis comparatively easy. On observation one may notice great diffusion of the area of cardiac dulness; it is downward and to the right side. There is

marked epigastric pulsation. There is little to be seen in front, but on the left side behind there is a marked throb, but no aneurismal bruit; there are no abnormal sounds over the heart, but there is marked accentuation of the second sound. There is that tendency to exophthalmic condition so often seen in cases of aneurism and aortic trouble. He had been a drinker and the first thing he complained of was pain between the shoulders. The apex beat of the heart is downward and diffuse and the mediastinum is pushed over to the right side. On the right side of the lungs there is found a decided increase of percussion resonance, almost tympanitic; on the left it is clear, but like the sound over a compressed lung, the dull tympanitic sound, Skodaic resonance. This points to pressure on the lung. On auscultation of both sides of the chest, the right side was found to do most of the work and there was puerile respiration. He did not think there was heart hypertrophy. The heart sounds were distinct. There was nothing marked at the pulse at the time of entrance and there were no pupil signs. Dr. John R. Winslow had examined the throat for him and had found a paralysis of the abductor fibres of the right vocal cord. It has been said that there is absence of pulsation in the arteries beyond the aneurism because the sac always being full of blood the vessels beyond that receive the blood in a steady stream and it flowed in them as in the veins. He thought he had found this condition of things probably because he wanted to find them, but he was mistaken, for pulsation was found in the arteries beyond the aneurism, only it was decidedly more feeble than at the radials. In looking at the situation of the aneurisms, he thought that aneurisms at the first part or ascending portion of the aorta were generally made known by signs, the signs were prominent and in the second part the symptoms were more marked, and in the third part they were very apt to erode through and to show themselves as a pulsating tumor.

In one case there was an aneurism just at the beginning of the aorta and in the pericardium, and when it broke leakage took place into the pericardial sac and death followed more from pressure on the heart than from loss of blood. In one case the aneurism leaked into the superior vena cava, as there was venous pulsation. The end may be sudden or it may be gradual, and in one case in which death had been almost instantaneous, at the post-mortem he had been unable to find the opening through which this blood had leaked and he was much chagrined at it until he found on looking up the subject that this was often the case. Death need not take place for several days after leaking has begun. He had put this case on the dry diet and gave iodide of potash in increasing doses, until now he was taking 27 grains three times a day. Dr. Tiffany proposed introducing sterilized wire through a hypodermic syringe to favor clotting.

Dr. S. C. Chew was also struck with the difficulty of finding the opening of leakage or rupture. He thought it was strange how a soft substance like an aneurism sac could erode a hard substance like a bone and he could not understand the physics of it. He thought that the iodides had a most remarkable power in producing lamination and diminution in the size of the aneurismal cavity.

Dr. F. T. Miles said that bone was very easily affected by pressure and its erosion was due more to the pressure cutting off the blood supply in the bone than to mere mechanical pressure; it was the difference in the character of the tissue. The trachea was affected in the same way by pressure. During our whole life bone is being absorbed and replaced.

Dr. W. B. Canfield said that he had seen very few cases of thoracic aneurism, but he had found them all easy to make out, possibly because they were far enough advanced to be evident. As Dr. Mitchell had said, the aneurism of the first part could be made out by the pressure effects and the others by their erosion. The presence of a pulsating tumor in the chest could point to but one thing and that was aneurism. He had seen one case in which the aneurism had eroded entirely through the bone and in which there seemed to be no disturbances.

Dr. S. Robert Kelly had seen three cases recently in his department in the University Dispensary and they had all been easy to make out.

Dr. Mitchell agreed with Dr. Canfield in saying that aneurism was easy to make out when it showed or when its pressure effects made one suspect it, but his post-mortem experience had shown him many aneurisms which had not been suspected during life and in which the symptoms and signs had not pointed to aneurism. There must necessarily be a long time before an aneurism of the descending arch appears behind, as any one would know who had tried to memorize the numerous muscles of the back. This man had complained for a short time only of pain in the back and yet the aneurism had begun its erosion long before his pains began.

Dr. W. B. Canfield showed a "Lumbricoid Worm" which had come from the larynx of a patient of his. He knew that the wandering habits of these parasites were well known and that his case was very common, but a case had never fallen under his personal observation. The woman drew the worm out of the larynx and partly coughed it up as it was making its way from the œsophagus to between the vocal cords.

Dr. S. C. Chew reported "A Case of Acute Phthisis With Rapid Fatal Termination." It was remarkable on account of its acuteness. He referred to a case terminating in five weeks and another in eight weeks. Loomis says the average duration of acute cases is from five weeks to five months, thus giving five weeks as the shortest time. His case had been apparently well until a very short time before death and in fact the man had passed as a good risk for life insurance about eighteen months or two years before that time and he himself had examined him, and on referring to his records he found that the man had no bad family history and had had no case of phthisis in his family. He saw him in consultation about three days before death and there was a temperature of 104° to 105°, marked dulness over the right lung from the clavicle to the diaphragm. About midway in the lung there was loud amphoric blowing, cavernous gurgling and whispering pectoriloquy. He had no rusty-colored sputa following the formation of an abscess, but there was evidently a large vomica from which muco-purulent expectoration came and an examination of the sputa

showed swarms of bacilli. He died about two or three days after this and the remarkable part of the case was that his death came on exactly twenty days after his first complaint of feeling ill, which is the shortest time he had ever seen. The man was about twenty-eight to thirty years old, and had absolutely no bad family history. There was no evidence of acute miliary tuberculosis.

The Ninety-Sixth Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland will be held in the Hall of the Faculty, April 24th to 27th, 1894. The sessions will be held from 12 M. to 3 P. M. and from 8 P. M. to 10.30 P. M. Members desiring to present papers at this meeting are requested to communicate their names and the titles of papers to one of the undersigned Committee on Programme before April 15th. Titles of papers received after that date cannot appear on the printed programme. Attention is called particularly to the by-law which provides that the time of reading of each paper is limited to 20 *minutes* and that in the discussions of the papers each member is privileged to occupy not more than five minutes, unless otherwise ordered by a two-thirds vote of the members present. The address of the President will be given on Tuesday, April 24th, at 12.30 P. M., upon "The Extinction of Tuberculosis." The Executive Committee take pleasure in announcing that the Annual Oration will be delivered on Thursday, April 26th, at 8 P. M., by Prof. James T. Whittaker, M. D., of Cincinnati, on "The Predisposition to Phthisis." The subject selected for general discussion, which will be held on Tuesday evening, April 24th, is "The Treatment of Empyema." Referee, Dr. C. W. Mitchell, on the medical aspects; Co-Referee, Dr. L. McLane Tiffany, on the surgical aspects. Drs. R. W. Johnson, J. W. Chambers, R. Winslow, I. E. Atkinson and others will participate in the discussion.

On Wednesday night will be held the Executive Session, at which reports of officers and committees will be made, officers will be elected and unfinished and new business will be considered. The annual banquet will be in the hall of the Faculty on Thursday night after the delivery of the annual oration. The price of tickets for the banquet is two dollars. George H. Rohé, M. D., President; G. Lane Taneyhill, M. D., Recording Secretary, 1103 Madison Ave.; Jas. M. Craighill, M. D., Corresponding Secretary, 1730 N. Charles St.; Louis McLane Tiffany, M. D., Chairman Executive Committee. Committee on Programme: William H. Welch, M. D., 935 St. Paul St.; Thomas A. Ashby, M. D., 1125 Madison Ave.; Charles W. Mitchell, M. D., 937 Madison Ave.; Harry Friedenwald, M. D., 922 Madison Ave.; J. W. Humrichouse, M. D., Hagerstown, Washington County.

At the monthly meeting of the directors of the Johns Hopkins Hospital, Dr. A. R. Oppenheimer was appointed assistant resident physician, and Dr. R. W. Carroll acting assistant resident physician.

A disastrous livery stable fire on Monday destroyed horses and carriages belonging to several physicians.

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BALTIMORE, APRIL 14, 1894.

Editorial.

THE ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY.

The preliminary announcement of the ninety-sixth annual convention of the Medical and Chirurgical Faculty, to be held in Baltimore, April 24th to 27th, has recently been issued. The presidential address by Dr. George H. Rohé will be upon "The Extinction of Tuberculosis;" the annual oration by Dr. James T. Whittaker, of Cincinnati, will be on "The Predisposition to Phthisis;" and the subject for general discussion, "The Treatment of Empyema," will be discussed by Dr. C. W. Mitchell as referee, and Dr. Tiffany as co-referee, to be followed by others. Members desiring to present papers are requested to communicate their names and the titles of papers to the Committee on Programme before April 15th.

At the last annual meeting it was decided to abandon the reports of sections, which had hitherto made up a large part of the programme, and to establish a Committee on Programme, which shall secure voluntary papers and, if necessary, solicit papers from the members. This abandonment of a time-honored, but outgrown custom, we believe to be wise.

The reports of the members of the various sections were often perfunctory, if they were presented at all. We may expect that the new arrangement will furnish a much more interesting and fresher list of papers. For the success of this plan, however, it is essential that there should be active interest and co-operation on the part of the members, who should be ready and willing to volunteer papers whenever they have anything to contribute. The near approach of the annual meeting should stimulate members to consider how they can add to its interest and attractiveness. The Faculty has shown increased activity and consequently has largely augmented its membership throughout the State during the past few years. A circular letter sent out with the preliminary announcement to physicians of the State makes a strong appeal to the medical profession of Maryland to support their State Society.

Every regular physician in the State should be a member of this organization, which would thus be rendered even more fully than now the responsible agency to speak and act for the whole medical profession of the State. Other State medical societies include in their membership all of the regular physicians of the State. Some of the unquestioned benefits of such an active and thoroughly representative State medical organization

are set forth in the circular. It is to be hoped and expected that this appeal to the interest of our physicians in the success of their State Society, which can serve the welfare of the profession in this State, and the advancement of matters relating to medical science and art, public health and medical legislation, will result in large additions to the Faculty at the approaching annual meeting.

The present medical law in its recently amended form is due to the initiative and activity of the Faculty, from whose members are selected the State Board of Medical Examiners. The Faculty thus resumes the relations which it held in its early years nearly a century ago toward the license to practise medicine in this State.

We regard as most hopeful the increased participation in our State Society of physicians from outside of the city of Baltimore. A large attendance of physicians from all parts of the State is desired. The establishment of medical societies in the counties has been due mainly to incentives from the Faculty and has resulted in mutual benefit.

Already attention is called to the celebration of the centennial anniversary of the Faculty five years hence, when it is hoped that the membership will include the great body of regular physicians in the State.

TYPHOID FEVER IN BALTIMORE.

In that comprehensive Report on Typhoid Fever, published by the Johns Hopkins Hospital, Dr. Osler shows what a great factor in the mortality rates of Baltimore typhoid fever exerts, and what measures, efficiently designed and effectively carried out, would reduce to a minimum the number of cases of this disease. The three desiderata for the extinction of this disease in any city are pure water, good drainage and a proper isolation of the sick. "Of sanitary essentials in a modern town," Dr. Osler adds, "Baltimore has a well-arranged water supply; still, however, with unprotected sources and constant liability to contamination. It has nothing else—no sewage system, no system of isolation of the sick, no hospital for infectious diseases, no compulsory notification of such a disease as typhoid fever, no disinfecting station, no system of street-watering, no inspection of dairies, no inspection of meat. The streets are cleaned, but so carelessly that a large part of the year the citizens breathe a mixture of air with horse-dung and filth of all kinds."

By a study of other cities it is seen that the introduction of a good water supply, or a proper system of drainage, at once reduces the mortality from typhoid fever. Baltimore has a fairly good water supply, but the last General Assembly of Maryland failed to allow Baltimore to provide herself with a proper system of sewers and consequently we shall go on for another term, storing house waste and excreta in our 70,000 to 80,000 privy vaults.

The conclusions which Dr. Osler has drawn are the following measures necessary for the prevention of this disease:

1. Scrupulous care on the part of physicians in charge of cases, that (*a*) the stools are thoroughly disinfected, and (*b*) that all sources of contamination are prevented from the soiled clothing, etc.; (*c*) active co-operation in notifying the health authorities of the existence of cases.

2. The presence of typhoid fever in a

city means bad drainage, or polluted water supply, or both, and since the morbidity and mortality may be reduced to a minimum by a proper sewage system and an ample supply of pure water, it behooves civilized communities to insist upon these elementary measures of public health. Baltimore has no sewage system, and has the unenviable distinction of having the largest number of privy pits of any city on this continent, the major portion of which are, in the words of Health Commissioner McShane, "filthy, unsanitary, threatening and positively dangerous." The experience of other cities warrants the statement that with a thorough system of subsoil drainage the death-rate from typhoid fever would be reduced from its present rate of above five per ten thousand living to between one and two. The water sources are unprotected and an increasing population along the streams, to use again Dr. McShane's words, "augments the danger of pollution."

3. To insure safety there must be rigid and frequent inspection of dairies and of the households of dairymen. The city may itself be clean and an outbreak of typhoid fever have its source in a polluted dairy many miles distant.

4. In the annexed districts and other sections the surface-wells should be abolished altogether.

THE ELEVENTH INTERNATIONAL MEDICAL CONGRESS.

The closing of the Eleventh International Medical Congress marks another epoch in the life of international medicine. The first meeting was scarcely international in character; indeed, it was almost accidental. It was during the great Exposition in 1867 at Paris, that it occurred to some of the committee who were then holding the annual French Medical Congress to invite all visiting medical men to be present at the congress and take part in its deliberations. As a result of this about five hundred foreign physicians were registered. French was the only language used. Bouillard was President and Ricord had charge of the surgical meeting, for there were no sections at that time. In 1869 the congress was held at Florence under the presidency of Dr. Salvatore de Renzi, who welcomed the profession in Latin. Then the Franco-Prussian war rather strained the relations between the countries, so that the third meeting was not held until 1873, at Vienna, during the Internationl Exhibition, also held there at that time. The older Rokitansky presided and here it was resolved to recognize as official the three languages, English, French, and German. M. Vleminckx was President of the fourth congress, which was held at Brussels, in 1875, with a large number of honorary Presidents from other countries. The fifth congress was presided over by Professor Karl Vogt and was held at Geneva in 1877. Then followed the sixth meeting at Amsterdam in 1879, with Professor Donders as President. The seventh at London, in 1881, with Sir James Paget as President, is so recent and the attendance was so large that it is still fresh in the minds of many. The eighth congress was held at Copenhagen in 1884 under the presidency of Professor Panum; the ninth at Washington in 1887; the tenth in 1890 at Berlin; and now the eleventh has just closed its sessions at Rome.

Symphysiotomy

A Successful Case A Suggestion

BY

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SYMPHYSIOTOMY.

A SUCCESSFUL CASE. A SUGGESTION.

The ancient history of symphysiotomy need not be rewritten. It is interesting in that it presents the reverse of what usually happens with new ideas in science. Its invention was hailed as a great advance in science, and laudation and honors were showered on the inventor. After a short reign the verdict was reversed. Harvey, Jenner, Wolff, Lister were regarded as dangerous innovators, but fought their way into universal recognition. Sigault was received with open arms by the profession, and after a short reign his operation fell into such disrepute that his very name was execrated by Baudelocque. One cannot wonder that, with bad pelvimetry, imperfect knowledge of pelvic deformities, and the sepsis which characterized all the surgery of the eighteenth century, the operation could not hold its own. From 1777 to 1804 there were forty operations; fifteen women and twenty-eight children died. The results of the second forty were about the same.[1] From 1858 to 1865 there are no recorded operations.[1] The paper of Dr. R. P. Harris read before the last meeting of the American Gynecological Society, and published in The American Journal of Obstetrics, October, 1892, leaves little to be said in regard to the modern history of the operation. Up to this time the attention of American obstetricians seems not to have been attracted to the revival which had been spreading in Europe since 1865. Dr. Harris' table, showing forty-four operations from January, 1886, to July, 1892, by various operators, with one maternal death, three still-born children, and two children dying respectively at twelve and seventy-two hours, made a profound impression on the American profession. I will not detain you by repeating details, but refer you to Dr. Harris' original paper and to the interesting one of Prof. Hirst, of the University of Pennsylvania.[2] Dr. Charles Jewett, of Brooklyn, was the first American operator. He operated on September 30th, 1892, under the following circumstances:[3] Healthy, robust primipara, age 22. In labor at 1 A.M. Head at vulva at 10.

[1] Harris.

[2] Medical News, October 15th, 1892.

[3] New York Jour. of Gyn. and Obstet., November, 1892.

Forceps impossible. Bisischiatic diameter about three inches. Antiseptic symphysiotomy. Head shelled out by fingers in rectum. Child died in twenty-four hours from effect of long-continued pressure. Recovery uneventful to date of writing. Fetal head: occipito-mental, 6½ inches; occipito-frontal, 5½ inches; biparietal, 3½ inches; circumference, 13½ inches.

Dr. Hirst operated October 2d, 1892.[1] Primipara, 19 years of age. Pelvic measurements: spinæ ilii, 25 centimetres; cristæ ilii, 27 centimetres; bitrochanteric, 30½ centimetres; conjugata externa 18 centimetres, interna 9½ centimetres; conjugata vera, 7¾ centimetres. Antiseptic symphysiotomy. Forceps. Child lived. Head: bitemporal, 7½ centimetres; biparietal, 9 centimetres; occipito-frontal, 12 centimetres; occipito-mental, 13½ centimetres; circumference, 34 centimetres. Mother recovered fully.

Dr. Broomall operated October 7th, 1892. I am indebted to Dr. Anna M. Fullerton, of the Philadephia Woman's Hospital, for the following account of the case: "Mrs. P., æt. 30, colored, multipara. Height, four feet eight inches; number of previous births, seven. Pelvic measurements: Distance between spines of the ilium, 23 centimetres; distance between crests of the ilium, 24 centimetres; conjugata externa, 19 centimetres; conjugata vera, 8¼ centimetres (probably less). A generally contracted, rachitic pelvis. Marks of rachitis in curvature of bones of skeleton generally, etc. Abdomen markedly pendulous. Child-bearing history: Early labors easy, increasing difficulty in later labors. The last labor, one of breech presentation, was very difficult; child lost. Present labor began with premature rupture of membranes at 2 P.M. October 6th, 1892. No dilatation of os; head of child presenting and movable above pelvic brim. Labor continued, with active uterine contractions, for twenty-four hours. Dilatation progressed somewhat slowly; the os, however, became dilatable. Head still perfectly movable above inlet; no attempt at engagement. Fetal heart slowed; sounds muffled. Mother showed signs of exhaustion in increased rapidity of pulse and rise of temperature (pulse 140, temperature 99.8°), frequent vomiting, etc. Inertia of uterus set in. Symphysiotomy was done October 7th, about twenty-four hours after onset of labor, after thorough antiseptic preparations. Galbiati's sickle-shaped knife was employed. Upon separation of the symphy-

[1] Medical News, October 15th, 1892.

sis the pubic bones sprang apart between four and five centimetres. The fetal head descended at once into the pelvis. The tissues being soft, sufficient dilatation was obtained by manual assistance for the application of forceps, and the child was delivered in about ten minutes without difficulty. (It cried lustily shortly after it was born, there being no asphyxia.) Wound closed with silk sutures and dressed antiseptically. Adhesive strips and a stout muslin bandage were used for fixation of the pelvis. The lying-in was without event. The temperature and pulse remained normal from within a short time after delivery. Patient not permitted to walk until beginning of fifth week. Locomotion perfect; union complete. Measurements of child's head: occipito-mental, 13½ centimetres; occipito-frontal, 12 centimetres; biparietal, 9½ centimetres; bitemporal, 8½ centimetres. Head well ossified; sutures close; fontanelles small. Weight of child, 2,780 grammes; length of child, 45 centimetres; sex, female. Mother and child in excellent condition up to date."

I operated at the Free Lying-in Hospital of the University of Maryland on October 25th, 1892. The patient was a rachitic negress, four feet six inches high, 17 years old. Pelvic measurements: spinæ ilii, 8¼ inches; cristæ ilii, 7¾ inches; bitrochanteric, 9½ inches; conjugata externa, 6 inches; conjugata vera, 2¾ inches. Labor began in the morning of the 24th and continued during the day. The waters broke during the afternoon. I saw the patient at 9 P.M. Os barely admitted two fingers; head large and no signs of engagement; both fetal and maternal circulation good; general condition of patient satisfactory. Concluded to wait for greater dilatation, and determined to operate next morning. Ordered pubes shaved and other preparations for the operation to be made. Operated at 9:30 A.M. Chloroform anesthesia. Os still small, but most of the amniotic fluid had escaped, and the fetus was suffering from pressure, as evinced by pulse, which was becoming more rapid and irregular. The fetal head was obviously large and there was no possibility of engagement. I first dilated the os uteri until four fingers would enter, having first evacuated the bladder. I then incised the soft tissues down to the symphysis, and separated the attachments of the recti for half an inch on each side. Passing my finger down behind the symphysis until it projected below, I (not then possessing the Galbiati knife) tried to follow it with a large

curved, grooved director. The projecting belly prevented this. I then incised the soft parts from the outside below, down to my finger tips, and tried to pass the director from below upward, but without success. Finally, using the director as a guide for the lower part of the symphysis, and my finger for the upper, I passed an ordinary curved, probe-pointed bistoury behind the joint and severed the cartilage. The separation, when the incision was first made, was about one-half or three-quarters of an inch. Applying Simpson's modifications of Tarnier's forceps above the brim, I delivered slowly, dilatation being very imperfect. The pelvis was supported firmly at the sides during delivery. The child was easily extracted. I was amazed at the pubic separation. I paused when it was at its highest point and found it two and seven-eighth inches. The child was alive, and I passed it over to my assistant, Dr. K. B. Batchelor. Upon inspection I found that, notwithstanding my caution, I had lacerated the cervix into the vaginal vault, the perineum to the verge of the anus, and the anterior vaginal wall into the operation wound. These lacerations were at once repaired with catgut, save the anterior vaginal wall, which was so close to the urethra that it was deemed wise to leave it. The wound of the symphysis was sewed with gut, the deeper stitches including the anterior and superior pubic ligament. The wound was completely sutured, no drainage being used. The surface was powdered with aristol and dressed with iodoform gauze. Broad adhesive strips encircled the pelvis and were covered by a firmly applied bandage. The woman was in a fair condition after the operation, but was a little slow in recovering from the anesthesia. The catheter was used always when she desired to urinate. The puerperium was uneventful. On the evening of the second day temperature 101°; afterward, for ten days, the evening temperature was about 100°, the morning about 99°. Little or no complaint of pain at wound. No complaint referred to sacro-iliac joints. Pain and local tenderness at right knee, probably from position in which it was held during the operation. Appetite good and general condition excellent during the whole puerperium. Catheterization was done aseptically by the house physician, and no vesical irritation followed. Bowels moved on the fourth day by enema. On the ninth day the patient, being able to handle herself well, was allowed to sit up in bed, which she did easily without aid. On the eleventh day she sat up a little

while in a chair. On the twelfth day she could walk well and firmly ; movement was, however, discouraged. There was no trouble at all except a little slowness in healing of the anterior vaginal wound. Within a month the patient walked up and down stairs, and at the present time walks all over the hospital, and walks as firmly as before the operation.

The child died on the third day, the death being due to pressure which had occurred previous to the delivery. The death was due doubtless to the fact that the operation was postponed for the night. There was some meningeal hemorrhage, some superficial extravasation of blood. There was a clot at the base of the skull and extravasation in the spinal canal in the dorsal region. The lungs were filled with hemorrhagic infarctions. The head of the child measured : occipito-mental, $5\frac{3}{4}$ inches ; occipito-frontal, $4\frac{15}{16}$ inches ; suboccipito-bregmatic, $4\frac{3}{8}$ inches ; biparietal, 4 inches ; bitemporal, 3 inches.

I show to you here the Galbiati knife, which I have procured since the operation. Dr. Hirst attempted to do the operation with an ordinary bistoury, but afterward abandoned it for the Galbiati knife, which aided him very much in the operation and of which he speaks very highly. I think one can only appreciate the importance of this instrument if he has attempted to do the operation without it. I am quite convinced, in the light of the experience which I had in this operation, that this knife would have been a very great aid.

It seems to me that the revival of symphysiotomy is one of the greatest advances in recent times ; it strikes at the point where we found the greatest weakness. Every conscientious obstetrician aims to do everything possible to avoid craniotomy upon the living child, and it is just in these cases, where the true conjugate comes above two and one-half inches, that we have to elect between craniotomy, Cesarean section, and symphysiotomy. The results of the Cesarean section in modern times are particularly brilliant, considering the amount of danger incurred. But under the most favorable circumstances there is an amount of mortality which is very grave, and which would naturally make one hesitate to risk the life of the mother for the sake of saving that of the child. I am fully convinced that a great many people who very earnestly and enthusiastically advocate Cesarean section as the elective operation, would be very loath to have the same operation performed on persons of

their own connection when the alternative presented itself in that form. The use of symphysiotomy strikes at this point—cases which come under the head of Cesarean section with relative indication. When one reflects that in the forty-four cases recorded by Dr. Harris in his paper there is only one maternal death, and that seems to have been in a woman whose condition at the time of operation was practically septic and might have ended fatally under any circumstances, the saving of maternal lives is certainly a point that would attract the attention and the approval of everybody interested in the subject of obstetrics. Naturally the great point in its success in modern times, as compared with its early history, is the antiseptic precautions.

In reflecting over the operation an idea occurred to me, which is the suggestion I have to make. The aim of obstetricians to prevent the operation of craniotomy on the living child is applied mainly to the cases which we have already considered. But there are certain other cases in which this operation becomes more imperative even than it does in contracted pelves. These are cases in which, from a bad presentation of the head, delivery becomes impossible at a stage in which it would be equally impossible to do a Cesarean section. These cases are represented by face presentation, posterior chin. If the chin can be made to rotate to the front by any device, thus transforming it into an anterior face presentation, delivery is not particularly difficult; but where the chin fails to rotate to the front, and where the devices ordinarily employed are unsuccessful, I think it has heretofore been thought best to follow out the views of Penrose and many others—that the performance of craniotomy should be carried out at once. When there is a fixed and jammed posterior chin there is no sense in waiting. It seems to me that the operation of symphysiotomy could be applied to just such a class of cases, whether the chin or occiput was posterior and the delivery impossible. It seems to me that we could thereby relieve the woman of danger and deliver alive the child, which we would otherwise have to kill.

I have examined this matter with the fetal head and pelvis as ordinarily used in obstetrical instruction, and which I bring now before you. Here is a head which is in a position of face presentation, chin posterior, and it is seen that delivery in this position is impossible. If you can rotate it, well and good; but you simply cannot do it except in a very small number of cases.

You cannot do a Cesarean section on account of the position of the head, but you can do a symphysiotomy; and if the symphysiotomy is done, you can get enough room to rotate the occipitomental diameter and produce flexion of the head, and with such flexion you bring the occiput down to the pubic arch, and at that point, of course, the direction of the mother's forces is changed and you have a delivery of the occiput in the ordinary way. I think this is perfectly feasible, and is demonstrated with the pelvic bones and fetal head in place.

In order to still further verify the matter (and I think we should always, so far as possible, deal with dead subjects before we proceed to work upon the living person) I took a fetus of large size, and a pelvis, with the soft parts attached, of comparatively small size. The proportions of the fetus and of the woman were such that without a considerable lubrication and preparation it was impossible to introduce the head in the pelvis in any of the so-called normal positions. But with lubrication we were enabled to produce the usual movements of delivery in the normal way, the head filling up the pelvis completely. Having demonstrated in that way the comparative size of pelvis and of fetal head, we then introduced the fetal head into the pelvis, produced a posterior rotation of the chin, and put on forceps and attempted to deliver, and found it utterly impossible. I then performed symphysiotomy, and I was really astounded at the ease with which, after the pubic bones had separated one and a half inches (estimated), we could, by pressing over the symphysis, produce a descent of the occiput; or, in other words, produce flexion of the head upon the trunk, and bring the occiput under the pubic arch, and deliver by extension in the usual way. The experiment on the cadaver in this way was so much like the experiment on the living child and woman that I was convinced, at the end of the experiment, that the operation was perfectly feasible. Whether this will come into practice or not it remains for the future to show; but, so far as I am individually concerned, I shall certainly make this attempt on the first case presenting. If this does succeed, it seems to me that it will very nearly take away the last peg of support from craniotomy on the living child, either for bad presentation or deformity. I hope this will result in the diminution of fetal mortality which follows bad presentation.

In a case where the occiput is posterior, and where the deliv-

ery of the child with forceps is accompanied by a great amount of violence which frequently results in the injury and death of the child, this operation may be indicated.

Statistics are remarkable both as to the safety of the woman and the healing of the wound. The woman is subjected to very little risk. The number of operations which have been performed during the present year the world over I present in a communication which Dr. Harris was good enough to send me last week. There have been twenty-six operations in all. Six of these are by Italian operators, eleven by French, four by German, one by Austrian, and four by American operators; the one which I have the pleasure to report being the last of the list. In this list there are no deaths of the mother. In the American cases, the child in Dr. Jewett's case died in twenty-four hours from the results of pressure, and in my own case the same result occurred at the end of the third day. In both of these cases, had the operation been more promptly performed, both children would doubtless be living. Both children were born alive, and the fatality was not due in the least degree to the operation. The amount of violence done to the fetus is a great deal less than in an ordinarily difficult forceps case, because the points of resistance are removed.

I append Dr. Harris' list of operations in 1892 up to date:[1]

CASES OF 1892, AS SENT TO ME THUS FAR:

Morisani, Naples	3	I., 6.
Novi, Naples	1	
Caruso, Naples	1	
Truzzi, Novara	1	
Pinard, Paris	8	F., 11.
Porak, Paris	2	
Tarnier, Paris	1	
Leopold, Dresden	2	G., 4.
Freund, Strassburg	1	
Zweifel, Leipzig	1	
Velits, Pressburg, Austria	1	A., 1.
Jewett, Brooklyn	1	U. S., 4.
Hirst, Philadelphia	1	
Broomall, Philadelphia	1	
Michael, Baltimore	1	
	26	

15 operators, 5 countries, no death. R. P. H.

201 W. FRANKLIN STREET.

[1] Since the receipt of this paper successful operations have been done in America by Springle, of Montreal (Mont. Med. Jour., January, 1893), child also recovering, and by Garrigues, of New York (unpublished). A fatal case (unpublished) has also occurred in New York in the hands of a very skilled operator.—ED.

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ORIGINAL ARTICLES.

ECLAMPSIA OF PREGNANCY.

I. C. BARNES, M. D., Topeka, Kan.

Authors vary as to the limitation of the term eclampsia; some confining it simply to clonic convulsions which may be idiopathic, symptomatic or sympathetic. But the eclampsia of pregnancy is recognized as having a significance peculiarly its own, due to existing complications in which loss of consciousness, tonic and clonic convulsions and coma follow each other in rapid succession.

While the eclampsia attacks may not be precipitated until labor occurs, or may of itself be sufficient to produce premature labor, or is delayed until the puerperal period, still it must be ascribed to conditions existing during pregnancy otherwise beyond the domain of eclampsia as defined by the obstetrician.

It is not my purpose to impose upon the members of this association by detailing the various theories which have been advanced from time to time to explain the phenomena of eclampsia.

You are all familiar with them, as also with the effect that no sooner has a theory been promulgated and seemingly firmly established upon tenable grounds by its originator, than other observers have presented a line of cases similar in nature and occurring under similar conditions, but ascribing a causation partially or wholly based upon deductions derived from very different physiological and pathological standpoints, and thus have formulated theories which have varied as widely.

It cannot be said that all or any of such deductions are absolutely without foundation, but that error has been made by dwelling too emphatically upon some one phase or manifestation or pathological condition to the exclusion of all others, and of confounding the results of certain conditions with causation; as for instance, ascribing the unconsciousness and coma to a primary anæmia of the brain centres rather than to an anæmia due to vasomotor spasms.

Also so subtile is the human mind, that waves of theories like fancies flit before the vision, and apparently fulfill all the demands that the manifestation of disease requires, but sooner or later the delusion is vanquished by the observation of real facts relating to the etiology of the disease, and these fallacies are expunged.

Again, cases will arise that will not accommodate themselves to any classification, and are known as the exceptions, exhibiting the same phases, but lacking the pre-eminent pathological and physical conditions necessary to ally them with *bona fide* cases.

While true theories very materially aid in the scientific treatment of disease, false theories likewise as greatly mislead, and since all theories are based upon more or less thorough research and the deductions derived therefrom, it follows that the more this research is aided by the modern appliances of minute workmanship in chemical, bacteriological and pathological departments, the less frequently will the etiology of eclampsia be ascribed entirely

to the failure of function of one organ of the body, precipitating upon the system toxic products from the non-elimination of effete material, producing irritation of the central nervous system and thus exciting vasomotor spasms, peripheral irritation due to pressure on tense tissues, or to the hydræmic condition of the blood during pregnancy, or to a neurosis, any more than can be estimated just the amount of disorder and irritation necessary to bring about a climax in certain individuals under other circumstances.

However, investigation of each case, with regard to all details, will enable an approximate estimate to be made which shall ascribe to the different complications existing, a proportionate degree of causation which for a certain period of time, in a certain individual, will destroy consciousness and furnish a stimulant to the vasomotor centres sufficient to set in tonic and clonic contractions the voluntary muscles of the body and thus impede circulation and respiration to a degree that endangers life.

It is not only important to know that a sufficient number of cases have presented symptoms and phases similar in character, and that pathological investigation warrants the explanations which have been made relative to the convulsions due to specified conditions existing during pregnancy, but also to allow latitude as we are obliged to in the etiology of all other diseases in ascribing a symptom to this or that departure from the normal balance of the human system.

Now, it is found that the great majority of cases exhibiting this phenomenon have albuminuria, and that the albumen is due to an acute attack of inflammation of the kidney or to a chronic inflammation upon which is superimposed an acute attack or a congestion, all of which give rise to a more or less complete suppression of urine; but it is also established beyond controversy, that not every woman that has albuminuria during pregnancy will have eclampsia; and that also complete suppression may exist without any untoward results, and that partial suppression is frequently unaccompanied by albumen in the urine.

Still, as a rule the greater number of eclamptics are albuminuric and they do have partial or complete suppression. So that the physician is enabled to successfully ward off many attacks by promoting the secretion of the inactive kidney and securing the elimination of products of disorganization through other channels.

This, as a preventative measure, is of prime value; but as an expedient of relief at time of attack is secondary to normal labor, or labor artificially produced. Hence, the gravity of the case is relative to the length of time supervening between the attack and the completion of pregnancy.

That to the kidney lesion only as a complication of pregnancy, can be ascribed such a certainty of serious results suddenly overwhelming the patient, is demonstrated by the fact that such a lesion existing without this complication does not usually give rise to convulsions unless in very advanced stages.

Some few cases exhibit clearly the neurotic element, in which the discomforts and complications of irritation due to pregnancy are sufficient to excite an explosion of nerve energy; or may properly be ascribed to causes independent of pregnancy, and, therefore, a coincident rather than a result.

It is difficult to understand why convulsions should cease upon the removal of the ovum from the uterus, since the kidney condition still remains unless the pressure of the pregnant uterus proved a sufficient cause to excite an already overcharged nervous system, or that blood pressure was lowered by the relief of distention of the abdominal parietes and more or less compression of abdominal viscera, permitting a filling of the blood-vessels of this region of the body so capable of draining the system of a large portion of its circulating fluid and accomplishing the result more effectually than by means of diaphoretics, purgatives and venesection.

This general relaxation secures greater amenability to therapeutical remedies, and in the majority of cases in the beginning of recovery, opening the way for relief of all other complications.

The complete or partial suppression of urine, which has herertofore resisted all efforts to induce secretion, is gradually relieved.

It would be rather difficult to explain why convulsions, if due to toxæmia alone, cease as soon as the uterus is emptied of its contents, while complete suppression

of urine still exists and consequently there has been no opportunity for the system to unload itself of the retained products of excretion except by the alimentary and cutaneous surfaces, which have hitherto proved ineffectual.

It is easier to see why the coma should become less profound and gradually disappear as the secretion of the kidneys resume normal sway and the power of elimination is gradually increased.

A variety of phenomena usher in an eclamptic attack, some of which are peculiar to eclampsia while others are common to many diseases, both organic and functional, and thus frequently allay suspicion unless care is taken to seek the cause of every symptom, subjective and objective.

The most obvious premonitory symptoms, however, are followed so closely by the attack that not much time is given to relieve the vasomotor tension by depletion through the alimentary and cutaneous surfaces, so that very frequently all efforts to avert are futile.

The same measures are employed for relief as for prevention, with the addition of venesection for immediate effects, and induced labor when all other means have failed.

It is not only a procedure to save the life of the mother but also that of the child which will not survive oft repeated attacks.

Unfortunately the cessation of eclampsia does not always secure uninterrupted restoration to health, since so serious complications accompany or follow that no available resources are able to restore the normal equilibrium.

The gravity of the case bears a somewhat constant relation to the number of convulsive seizures, the greater the number the more unfavorable the prognosis.

REPORT OF CASE.

The case that came under my observation at the Hospital two years ago presented the following characteristics:

The patient was comatose when my colleague arrived, with a history of several convulsions in the last six hours, at the beginning of which, she relapsed into an unconscious condition from which the attendants were unable to arouse her.

A physician in the vicinity was called in, who gave her a purgative and left a sedative mixture with the advice to the friends to get her into a hospital.

Three hours later a message was sent for assistance without specification as to kind.

I was detailed to attend the case which I supposed to be an instrumental delivery; but upon arrival found the condition of affairs as mentioned.

Vaginal examination revealed a cervix of considerable length, an internal os completely closed, with no fixation of presenting part—in fact no attempt at delivery.

The convulsions were typical, and ten were reported within three hours. The bowels had been moved by an enema and the catheter passed but no urine obtained.

An anæsthetic was given at time of convulsions, and also two hypodermics of sulphate of morphia of $\frac{1}{4}$ grain each, during afternoon.

There was no convenience for baths or necessary care in the lodging house of the tenement quarters in which the patient was found, and the only chance for successful treatment lay in the possibility of getting her into the hospital.

Although fearing that the ride in the ambulance of five miles over cobble stone streets, might excite convulsions of so great severity that death from asphyxia would result, yet the journey was accomplished with very little inconvenience and no symptoms of increased irritation were present. The one convulsion came about the regular interval and did not surpass former attacks in severity.

At 7 P. M. arrived at hospital and the patient was immediately placed in a hot bath which was prolonged half an hour. She had two convulsive seizures during the time. A hypodermic of sulphate of morphia $\frac{1}{4}$ grain, was given and a drop of croton oil on tongue.

Phlebotomy of left arm was attempted but unsuccessful, the blood either would not flow, or the incisions were made into superficial veins rather than the deep ones.

Potass-bromide sixty grains and chloral twenty grains, were given by rectum and at 8.20 patient replaced in hot bath and removed in ten minutes.

A few minutes later had two convulsive attacks in quick succession.

Phlebotomy of right arm attempted with little success.

At 8.45 patient had a very severe convulsion and was replaced in hot bath to be removed in ten minutes to a hot pack.

Twenty minutes intervened when convulsive seizures returned.

Vaginal examination revealed the presenting part high, considerable cervix and no attempt at dilatation of the internal os. After some manipulation in this direction an attempt was made to introduce a Barnes dilator, but unsuccessfully.

Forty minutes later there was a severe attack lasting 1¾ minutes.

Patient again placed in hot bath—seventy-two minutes later two more severe seizures, seventeen minutes apart and lasting one and one-half minutes. The pulse 170 and respirations 40.

At 10.33 P. M., a soap and water rectal injection was given and retained.

Fourteen minutes after there was a convulsion of the right side only. Patient was taken from bath in which she had been placed and a catheter passed but no urine obtained.

Dry cups placed over the kidneys and a hypodermic of one-sixth grain of pilocarpin given.

11.56 P. M., A convulsion of right side only and in sixteen minutes another which, in twenty minutes, was followed by a general convulsion.

The temperature was 105.2° A hypodermic of morphine sulphate one-fourth grain was given, and Barnes' dilators successfully introduced. There being a slight attempt at dilatation, this was followed by a convulsion.

Patient placed in hot bath; thirty minutes after there was another convulsion, followed in thirty-five minutes by a convulsion of right side; was taken from bath and put into hot packs and catheter passed but no urine obtained.

Soap and water rectal injections given and retained. In fifty minutes there was a convulsion of right side. The water from retained injections was drawn from the bowel with a rectal tube.

Fifty minutes later a general convulsion supervened. The temperature was 104.6.°

At 6.30 A. M., February 16th, the chloroform which had been given since admission to relieve the intensity of convulsions was increased until complete anæsthesia prevailed. The membranes were ruptured and version attempted but abandoned.

Artificial dilatation being sufficient to deliver, forceps were applied, the head, which was the presenting part, fixed and craniotomy performed. This permitted artificial delivery.

Lacerations of the cervix and perineum were remedied by primary operations. Complete suppression of urine still existed.

A hypodermic of ergot, the fluid extract, twenty-five minims was given, and a ten-grain quinine suppository.

The pulse was 200. A hypodermic of digitalis and also one of pilocarpin was given half an hour afterwards with cups over kidneys and steam bath.

At 9.20 A. M. the catheter was passed and obtained a small amount of urine the first in twenty-four hours, or rather since the patient was taken in charge.

The convulsions ceased immediately upon delivery. Hypodermics consisting of tr. of digitalis five drops and aromatic spirits of ammonia five drops, were given every two hours through the day. Quinine suppositories, five grains every three hours. Peptonized milk given by rectum and cups applied over kidneys.

During the afternoon the restlessness and muttering delirium was relieved by bromides and chloral and cups applied to nape of neck and spine.

One-sixth of a grain of elaterium was given in butter on the tongue.

During the convulsions the patient had almost severed a portion of the left side of the tongue and the inflammation and slough served as an impediment to respiration.

At 6.30 P. M. the breathing became labored with symptoms and physical signs of congestion of the lungs, and flax-seed poultices were applied over the chest.

During the night the restlessness was controlled by bromide and chloral. The pulse was 140 and temperature 103.°

A cough mixture containing ammonium salts was ordered to be taken every two hours.

During the morning of February 17th, a steam bath was given, but since the kidneys were secreting fairly well the cups were discontinued.

About noon patient began taking food and medicine by mouth, and aroused from her coma to a degree that she was able to speak a few words intelligently; the most favorable symptoms since entrance three days before.

In the evening a hypodermic of the hydro-bromate of hyoscine was given, $\frac{1}{100}$ of grain for restlessness.

The pulse was 130 and temperature 104.6.°

The secretion of urine since three hours after delivery gradually increased in quantity, although the albumen fifty per cent. of specimens examined failed to diminish perceptibly. Hyaline, granular and fatty casts were abundant; also blood and granular debris.

During the earlier hours of the evening, however, the pulse became more feeble and respiration more difficult and the coma, which had been partially relieved, deepened, and at 2 A. M., February 18th, the patient died.

Post-mortem examination revealed the lungs œdematous, abdomen filled with dropsical fluid, chronic parenchymetous nephritis with evidence of acute attack.

No examination of the brain was made.

(The pregnancy was eight and one-half months advanced and the lochial discharge normal in quantity and consistency —there being no tendency to excessive hemorrhage.)

There were thirty-six convulsions from noon February 15th, to the morning of February 16th, at 6.30 A. M., with a probability of ten to fourteen before the physician arrived, making about fifty in all and thus coming in the scope of the mortality of fifty per cent. as recognized by the best authorities.

CLINICAL LECTURES.

SENILE AND SECONDARY CATARACTS AND THEIR TREATMENT.

EDWARD JACKSON, A. M., M. D.*

Gentlemen: We will to-day consider the operative treatment of cataract, different phases of which are illustrated by some of the cases to which I wish to call your attention.

SIMPLE EXTRACTION FOLLOWED BY PURULENT CONJUNCTIVITIS; RECOVERY.

Mrs. K., aged sixty years, came here three months ago, complaining of gradual failure of vision, which had progressed until with the right eye she was barely able to count fingers at two feet, and in the left eye she had only light perception. Each pupil was occupied by an opacity of the lens. With the ophthalmoscope the gray of the lens was in the right eye faintly tinged with the red of the fundus reflex, but in the left eye no trace of the fundus reflex was visible. She had in both eyes good quantitative perception of light; that is she could tell promptly and correctly when the light in the dark room was turned up or down, or brought near or removed farther from her. She had also good light projection; that is she could recognize the position of the light in whatever portion of the field of vision it was held. She had therefore senile cataract, uncomplicated and presenting all the indications for operation.

I removed the lens from the left eye by the operation which I now propose to perform on its fellow. The operation itself was without special difficulty or complication, but the next morning the lids were œdematous and the conjunctiva swollen. Within forty-eight hours there was a free purulent discharge from the conjunctiva, so that by the third day she had to be removed from the ward for operative cases for fear that other patients might be infected. On the fifth day the conjunctival discharge was so profuse that the checking of it became a matter of paramount importance, and we commenced the application of a strong solution of nitrate of silver to the everted lids. The healing of the corneal wound was not, however, interrupted, its closure and the refilling of the anterior eye chamber having occurred within the first twenty-four hours; and three weeks after the operation the conjunctival inflammation was well under control, and with the proper correcting lenses she could read part of the ten metre type at five metres.

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She now returns to have the cataract removed from the right eye. This I proceed to accomplish by the operation of simple extraction. I make a section of the cornea entirely within the clear corneal substance, parallel with the sclero-corneal junction and extending over almost half its circumference. Having completed the section, before laying the cataract knife aside I use its point to open the capsule of the lens. The cutting of the operation is now completed. To effect the delivery of the lens I take in the right hand a tortoise-shell lens scoop with which to make pressure on the eye-ball at the lower part of the cornea, and in the left hand a narrow corneal spatula with which to make counter-pressure on the upper lip of the corneal wound, if it is needed, or to aid in other ways the expulsion of the lens.

The pressure on the lower part of the cornea is made steadily backward, toward the centre of the eye-ball pushing back slightly the lower part of the lens, and being transmitted through the vitreous so that the upper margin of the lens is forced forward, dilating the pupil and entering the corneal wound. This pressure is steadily maintained and augmented until the widest diameter of the lens nucleus emerges through the corneal opening. The escape of the lens lessens the pressure within the eye, but some pressure is steadily maintained until all the cortex has escaped that can be delivered in this way.

In this case there still remains a little lens cortex within the eye, and for its removal I employ washing out of the anterior chamber with a solution of common salt by means of Lippincott's syringe. By directing the stream upon the iris it is made to straighten out in the anterior chamber assuming its normal position. During the washing you notice that quite marked contraction of the pupil has occurred, so that now we have the small circular pupil that is desired at the close of a cataract operation. Still, I will instil a drop of a solutioon of eserine sulphate one-quarter grain, to distilled water one fluid ounce, believing that in doubtful cases its influence is in the direction of preventing prolapse of the iris or its adhesion to the cornea. And to make the result most secure such an instillation is repeated at each dressing until the anterior chamber has been permanently refilled with aqueous humor.

After washing out the conjunctival sac and margins of the lids with a boric acid solution, the patient is told to keep the eyes closed very gently and this dressing is applied. Two or three thicknesses of absorbent gauze are laid on the lids and over this a light mass of absorbent cotton, and the whole held in place by strips of adhesive plaster passing across it from the cheek to the brow. This makes a comfortable dressing that protects the eye from infection, secures it rest, absorbs all discharges, makes no pressure, and is not liable to be dragged by movement of the head on the pillow, as is any form of bandage passing around the head. Its worst defect is that the plaster pulls on the skin when you come to remove it, and is liable to cause the patient to squeeze the eyelids tightly shut. You must guard against this by seeing that the strips of plaster do not catch any of the eyebrows or hairs that they can pull on, and that they are not longer than is necessary.

Such a dressing I continue to use four or five days, changing it usually twice a day, unless the conjunctiva show signs of hyperemia, which is always provoked or aggravated by the poulticing effect of a thick dressing, and whenever evidence of such an effect is noticed I replace this dressing by a couple of strips of gelatine plaster applied directly to the lids; a dressing that does not so well guard against wound infection and is rarely so comfortable, but which avoids the retention of heat and moisture that gives the thicker dressing something the influence of a poultice in causing or aggravating congestion or inflammation of the conjunctiva.

[In this eye there also developed a sharp conjunctivitis with considerable purulent discharge. It was treated in the same manner and the healing proceeded normally, the patient getting her cataract glasses at the end of four weeks, and having with them vision equal to 5-10ths mostly.]

SIMPLE EXTRACTION; PROLAPSUS OF THE IRIS.

This man, P. H., aged sixty-five, had a cataract extracted nine days ago. The lens was large and consisted almost entirely of firm nuclear substance, and this being suspected before the operation, to get as long an incision as possible I placed it nearer to the iris than the usual

point of selection. The patient, too, was restless, and during the first twenty-four hours there occurred a prolapse of the iris. The use of eserine reduced its size but did not entirely restore it, and you now see it as a brown swelling of some two millimetres in diameter at the centre of the scar of the corneal incision. It is now probably at its maximum, and from this time on will shrink until there is nothing left to mark its location but a dark speck in the line of the corneal scar.

This condition, while it is by far the most serious complication that is liable to succeed the simple extraction of cataract, is not nearly so grave an accident as might be supposed from our knowledge of the tendencies of prolapse of the iris occurring after other corneal perforations. In this connection it seems to be quite free from the tendency to go on increasing that makes it so disastrous in many cases of perforating ulcer or laceration of the cornea. This difference is probably due to the altered relations of the iris to the cornea brought about by the removal of the lens from behind it.

This absence of any malignant tendency to persistent increase or to keeping up an inflammation of the iris and related parts, leaves little excuse for any heroic treatment of the prolapse. It is neither necessary or advisable in the mass of cases to incise it or excise it, or even to touch it with the galvano-cautery. In a case of very extensive prolapse it may be proper to resort to one of these measures, but such cases are quite exceptional. You must bear in mind also that a very small part of the iris constituting a prolapse will, at a certain stage, be distended so as to look much larger than it really is, and that its apparent size will vary from time to time according to the amount of such distension. The active treatment had better be preventive, the placing of the corneal incision well in front of the iris, doing an iridectomy where the iris cannot be fully returned to normal position at the time of operation, and the regular instillation of eserine if it is so returned. Then, if the prolapse does occur some time after the operation, treat it on the expectant plan, and the ultimate result will be almost as good in these worst cases of simple extraction as it is in the average case of extraction with iridectomy.

The occurrence of prolapse somewhat protracts the process of healing, increases, at least for a time, the amount of post-operative astigmatism, and prolongs the period during which the astigmatism is diminishing, and so delays the final adjustment of glasses. But my impression is that so far as its permanent usefulness, and continued sound nutrition and freedom from liability to other disease are concerned, an eye that has suffered prolapse after the simple extraction of cataract is as safe as an eye that has suffered iridectomy during the operation.

[From this time the prolapse diminished, the eye was free from irritation by the thirtieth day when he left the hospital. Glasses were finally adjusted in the eighth week after the extraction. He required +12. sph.+3.D.cyl. axis 175° and with this he had vision=5-15ths, which can undoubtedly be improved materially by needling the lense capsule.]

SECONDARY CATARACT; OPERATION.

From this man, J. G., aged sixty-three, I removed both lenses for cataract a little over a year ago. The operation done was the simple extraction, and it has left the perfect iris and pupil that some suppose are its chief advantages, but which are usually quite subordinate to its superior safety and greater ease of accomplishment. The right eye was operated on first, and the left a few days later. In the right it was found that some opacity of the capsule or remains of cortex interfered with the result of the extraction, so the capsule in that eye was needled. He left the hospital with 5-5ths. vision in the right eye and 5-10ths. vision in the left, with his correcting glasses.

He returns now with the vision in the right eye still as good as ever, but complaining that there has been progressive failure of vision in the left eye. As this is the eye in which the capsule was left undisturbed, I immediately suspect that changes in that membrane, either partial opacity or wrinkling, are the cause of the progressive loss of vision. Certainly in a large majority of cases, if not in all, there occur within a year or two after the extraction of the lens secondary changes in the remaining portion of its capsule that unfit it for the proper transmission of light, and render some secondary operation necessary in order that the patient may enjoy the best possible vision.

Upon examination by oblique illumination and with the ophthalmoscope we find the capsule wrinkled and partially opaque in each eye. But in the right there is a triangular opening in this membrane through which the patient sees clearly. In many of these cases although very little opacity is to be found the wrinkling alone, by the irregular astigmatism that it causes, constitutes a complete bar to good vision, and that is just the condition of this case.

I shall now attempt to make a sufficient opening in this wrinkled capsule to allow of good vision through it. Such an opening does not have to be very large, yet it is often quite difficult to secure it on account of the extreme elasticity of the membrane with which we have to deal. In order to get as free movement as possible for the cutting edge of the needle, the entrance is made at the extreme periphery of the cornea. At this part the needle is necessarily fixed and the farther away the point of cutting the capsule from this fixed point the freer the movement of the cutting edge. Sometimes to get still freer movement it is well to introduce the needle through the sclerotic, back of the ciliary region, and make the cut in the membrane from behind.

In this case I introduce the knife-needle at the periphery of the clear cornea on the temporal side, pierce the membrane near the lower nasal margin of the pupil and make the incision thence to the lower temporal border. Then the knife is withdrawn sufficiently to bring its point in front of the membrane and it is made to transfix it at the upper margin of the pupil and cut downward. In this way a T-shaped incision is secured, which is dilated by protruding viterous into a sufficiently large clear pupil.

For the after treatment of this case, duboisin sulphate is to be instilled twice a day until the eye is quite free from redness. For the first few hours he will have the eye covered with a little absorbent cotton and this muslin shade which we call here a "Liebreich bandage," although it is entirely different from the knitted bandage described by that London surgeon. This closing of the eye is merely to exclude external contamination, until the little corneal wound is quite closed, which will be in a very few hours. After that he will wear dark glases until the effect of the duboisin has passed off, and before he leaves the hospital we will carefully test his refraction again. Not because it is likely to be changed by this operation, but to see if it has changed materially since shortly after the primary operation when his glasses were adjusted.

Drunk or Dying.

The uncertainty of diagnosis in head injuries has once more been illustrated by a case that recently occurred at the San Francisco Receiving Hospital (*Occ. Med. Times*). On September 3, 1892, M. C. Shaw, aged 37, a civil engineer by profession, was knocked down by a cable car. He was dazed by the blow, but seemed to recover consciousness in a few minutes. The patrol was summoned, and, though he protested he was not hurt, and wanted to go home, his friends thought best to bring him to the hospital. The assistant surgeon on duty found several abrasions and contusions about the forehead, but no certain signs of serious injury. The patient, however, presented apparent symptoms of intoxication. He had walked into the hospital with a slightly unsteady gait, talked a great deal, declaring that it was nonsense to dress the abrasions on his head, took money from his pockets to pay the surgeon and steward for their trouble, and in many ways acted as an intoxicated person would. From the nature of the accident, however, the surgeon suspected that there might be internal injuries, and accordingly entered the diagnosis on the books as "doubtful." The man was placed in the hospital ward and kept for observation. He appeared to fall asleep at once, but never awoke. Six hours after entering he died. A post-mortem examination showed fracture at the base of the skull, in the occipital bone. The external injuries were all in the fore part of the head, and as the occipital region showed no wound, the fracture was evidently from contre coup.

"Who makes the kittens, Jackie?" "Why, God makes them, Ethel. He doesn't make them as He does babies, one by one, but He just says, 'Let there be kittens,' and there are kittens."

COMMUNICATIONS.

HYPODERMATIC MEDICATION IN SYPHILIS.*

L. WOLFF, M. D., PHILADELPHIA.†

Amongst the therapeutic methods which are largely employed on the continent of Europe, but have found very few adherents in this country is, no doubt, the hypodermatic treatment of syphilis. Although proposed and practiced in the early part of 1860, it was some time before it was extensively employed even abroad. This was, no doubt, largely due to the fact that it was little understood, that, from temerity, the doses employed were by far too small, and results, therefore, not brilliant, as well as from fear of the formation of abscesses and the necessary amount of pain accompanying such medication. The pain accompanying it is to-day still an argument against its employment that is not to be overcome. If we, however, consider that in the principal medical centres of continental Europe little or almost no mercury is given internally any more, even the pain accompanying and following the injections must be outweighed by the results. While the first experiments on hypodermatic medication in syphilis were made with solutions of corrosive sublimate, the insoluble mercurials were soon substituted by Scarenzio and others. Therefore, we may divide the mercurials into those preparations which are soluble and those which are insoluble mercurials. It was found that if insoluble mercurials were introduced beneath the skin they were rapidly absorbed, that they were soon found in the urine, and, also, often produced the untoward effects of mercury, besides their characteristic inhibiting and curative influence over the lesions of syphilis.

In a former paper on this subject (*Therapeutic Gazette,* November 15, 1889) I dwelt on the history of this method of medication and gave, also, a synopsis of the literature on the subject. I shall, therefore, in this paper, consider principally my experience with this treatment and with the various agents so employed. During my student days I had the opportunity of watching and practising this method, and I have continued to employ it to this day in a large and varied practise which has brought, perhaps, to me an unusual number of cases of early and secondary syphilis. Though I have again and again abandoned it, owing to the pain it occasioned, I have always had to revert to it in order to satisfy my patients, who, if they had been treated hypodermically once, and were then treated with mercurials taken by the mouth, would gladly stand the pain of the injections rather than the slow results and the digestive derangement caused by the older methods of medication.

I usually begin the injections of corrosive sublimate in the intra-scapular region on one side and about two inches from the posterior vertebral processes, and continue down the back in the costal interspaces—the injections being about one or one and a half inches apart. The effect of the injections on still open primary sores, on indurated glands, on macular syphilides, and on pharyngeal ulcerations may be said to be almost magical. It is noticeable that within a few days, and usually within one week or ten days, all these signs have disappeared. The same beneficent results may, also, be said to take place in specific iritis and choroiditis, and it is especially in these two affections that I consider the hypodermatic administration of corrosive sublimate, in the doses and manner mentioned, of the greatest value. Papular eruptions do not show the same tendency to disappear rapidly under the hypodermatic treatment, but have usually faded within a few weeks. The effect on luetic fever and nocturnal pains is so marked that with the first or second injection the patient notices a marked improvement. I never use less than a one-fourth grain injection at one time and generally employ a one per cent.

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solution in distilled water, filling a syringe of twenty-five minims capacity. These injections are continued daily, and during the first week or two patients stand the treatment fairly well. There is rarely, during this period, any evidence of soreness of the mouth or gums, nor is there any intestinal trouble noticeable. After the entire back, on both sides, had been gone over with injections, many of which have left quite sensitive indurations, their repetition in or near the old places prove quite painful, and it is only then that real complaints from patients are heard. Usually after eighteen or twenty injections tumefaction of the gums becomes marked, and gingivitis is often noticed. The daily injections are then intermitted, and are made at intervals of two, three or four days, the untoward symptoms rapidly disappearing during such intervals. The total number of injections usually made in any one treatment is about twenty-five, but I have continued them to the number of thirty or thirty-five, when marked pigmentation of the local lesions supervened. A good rule may be to carry on hyper-medication for about two weeks after the total disappearance of all symptoms. It is, of course, understood that during this time the patient is to be supported by a liberal diet, by milk punches, and, when the digestion is impaired, by tonics and quinine. The mouth should be kept scrupulously clean, the teeth being cleansed after each meal and at bedtime with a soft brush dipped in a solution of one drachm of potassium chlorate to six ounces of water, and containing, also, a drop of carbolic acid to each fluid ounce. While warm full baths or steam and hot-air baths are adjuvants to the treatment, the cold bath should be interdicted as well as exposure to cold and deprivations. I may safely say that I have made thousands of these injections, and have yet to record a case where they have been followed by abscess or sloughing. All of my cases so treated were ambulant, and I do not remember that any of them have lost a day from their usual vocations.

The immediate effects of the corrosive sublimate have been so uniformly good that I need to consider now only the remote effects on the progress of the disease and its liability to relapses. The permanency of a remedy in syphilis is one of the features of the greatest importance, and here I must say that as rapid as is the beneficial effect of this method of medication, there is a corresponding large number of relapses. Of the cases that I have so treated, and of which I have been able to keep a record, I can safely state that in about 60 per cent. no further symptoms developed. I have notes on a number who subsequently married and raised apparently healthy offspring. Of the remaining 40 per cent., however, I cannot say that they have done so well, and many of them after receiving two, three, and even four courses of treatment by injection had to submit to treatment by systematic inuction before the tendency to relapse has been overcome.

It is this tendency to relapses which has caused me to abandon hypodermatic injections after a second failure as to permanency of cure. It made me investigate the many other mercurials suitable for hypodermatic medication. It has been experimentally proven by Vajda, of Vienna ("Ueber den Einfluss des Quecksilbers auf den syphilitischen process"), that the iodides inhibited the elimination of mercury by the kidneys, and that the slower the elimination the greater the safety from relapses. For this reason it has been my practice to give from five to ten grains of potassium iodide three times daily, after the injection treatment, for months to come; but even this plan has not always prevented frequent relapses. Acting on this indication, and at the suggestion of my friend Dr. Thomas H. Fenton, I have tried injections of iodo-hydrargyrate of potassium, a compound of iodine and mercury, but I have found these injections no less painful, and their permanency has not been greater in my hands than with the corrosive sublimate treatment. In respect to permanency, it is said that the injections of the insoluble mercurials are of greater benefit than the soluble ones. This might be inferred from the fact that their conversion into a soluble compound beneath the skin is a slower process, and while thus a mild continued mercurialization is produced the injections need not be repeated so often. The insoluble mercurials have, however, the disadvantage of not being always aseptic, nor of being readily rendered so. It is true that with the introduction of vaseline oil as a vehicle for their hypo-

dermatic administration they can be rendered both less septic as well as less painful.

At the head of the insoluble preparations, so far as efficiency is concerned, calomel must figure. I give below the formula for its use, as well as the formulæ for other of the insoluble mercurials, according to Professor Edward Lang in his "Ordinations Formeln:"

℞ Calomel, Vaseline oil, Lanolin ..... āa 4.5 grammes.

Each c.cm. contains 0.371 grammes of mercury, 0.1 c.cm. to be injected not oftener than two or three times the first week.

The precipitated mercuric oxide (hydrarg. oxid. flav.) comes next.

℞ Yellow oxide of mercury ..... 4 grammes.
Vaseline oil ..... 4.5 "
Lanolin ..... 3.5 "

Each c.cm. contains 0.391 grammes of mercury. To be used as the calomel injection.

The salicylate of mercury is lauded very highly, and is prepared for injection as follows:

℞ Salicylate of mercury ..... 7 grammes.
Vaseline oil ..... 4 "
Lanolin ..... 2 "

Each c cm. contains 0.391 grammes of mercury.

The latest preparation and, at the present time, the one generally employed in the hospitals of Paris, even by the veteran Fournier, is the mercurous oxide, which is really a mercurous-mercuric oxide, but better known as the black oxide of mercury. It is used as per following formula:

℞ Black oxide of mercury ..... 4.7 grammes.
Vaseline oil ..... 6.2 "
Lanolin ..... 3.1 "

Each c.cm. containing 0.39 grammes of mercury, and to be used as the other preparations.

I might go on and quote in the same manner the thymol-acetate, the diphenylate, and the sozoiodolate of mercury and other forms of the drug, but, as those named are the preparations generally used, I will omit the others.

It will appear from the above that, after all, the virtues of the preparations quoted consist in the amount of mercury they contain and in the slowness of its conversion beneath the skin. The more rapidly converted the sooner the lesions disappear, the more mercury introduced with safety to the general health the greater the curative effect on syphilis; but the slower and more persistent the conversion the greater the permanency of the treatment and the likelihood of a total extinction of the syphilitic poison. It may be said against these insoluble mercurials, and with some force, that their advantage over the soluble preparations is only by their slower action, while the marked local reaction which they produce is quite as much as with the soluble mercurials. Such is really the case, and the desideratum, therefore, seems to be to employ a preparation that will produce the least reaction and that will be slowly converted, while least in its probability to produce untoward effects. Professor Edward Lang, of Vienna, some years ago experimented on the direct introduction of metallic mercury in minute subdivision as being nearest to the ideal method of inunctions, which yet hold the highest place in permanency in the treatment of syphilis. He found that they were readily borne, that they produced little or no local reaction, and, an acconnt of the slow conversion of the mercury, needed repetition only at long intervals. He claimed that the introduction of the metalic mercury hypodermically exercised an influence over the syphilitic process which was in direct proportion to its conversion, which could be studied by its excretion through the kidneys. This appealed to me as one of the methods most likely to prove more permanent than any of the others, and I introduced it in my private practice as well as in the wards of the German Hospital under my control.

To fully describe this method I must mention the manner of its preparation for hypodermic use, as given by Professor Lang in his "Ordinations Formeln." This consists in first making an ointment of mercury with lanolin, as follows:

Anhydric lanolin, 15 grammes; dissolve in q. s. chloroform 50 grammes, and evaporate the cloroform by continued stirring until the weight is 30 grammes, then add pure metallic mercury, 30 grammes, and continue stirring until all the chloroform is evaporated and the mercury is perfectly extinguished. (This can be recognized, if, by spreading with a spatula on paper, no mercury globules are visible by means of a magnifying glass).

This is his strong lanolin mercurial ointment, and it forms the basis for his oleum cinereum or gray oil. Of the latter he has two preparations, according to the dilutions, the 50 per cent. and the 30 per cent. oil. The formula for the former is as follows:

℞ Strong lanolin mercurial ointment..9 grammes.
Olive, almond, or vaseline oil..... 3 "
Mix well.

This contains in each 0.05 c.cm. to 0.04 c. cm. of mercury. 0.05 c.cm. is the average dose for injections, but if it is desirable to inject double the quantity it is best done in two different places. To produce a very active effect it is advisable to inject twice a week 0.05 c.cm. of this strong oil until all symptoms have disappeared. After that, and to prevent relapses, 0.05 c.cm. should be injected about once a week or once in two weeks for some time afterward. All injections should be made, beneath the skin, in the back, about one inch from the median line, the semi-solid mixture being previously warmed by immersion in hot water until it becomes fluid. Lang also makes use of injections of 0.05 c.cm., two to four times during the first week, and subsequently every week, and later every two weeks, the same amount. He also recommends a milder gray oil, made as follows from the strong lanolin mercurial ointment:

℞ Strong lanolin mercurial ointment 4.5 grammes.
Oil of sweet almonds (or olive oil or vaseline oil) ..... 5.5 "
M.

Each c.cm. of this contains 0.366 grammes of this mercury. This is termed the 30 per cent. gray oil. Of this oil one-tenth c.cm. is the average injection made in two places of the back.

These formulæ, complicated as they may seem, can be easily worked out, and when once the lanolin mercurial ointment is made the dilution requires very little time, as but small quantities are required; a half ounce will last for weeks and, if necessary, should be made fresh every month or two, although these oils really keep a much longer period.

The syringe for injections should be accurately gauged and sub-divided into 0.1 c.cm. and tenth parts thereof. The syringes, as made by Reiner, also Leiter, of Vienna, are used for that purpose, the total capacity of each being a half of a cubic centimetre. They have been accurately gauged, and a certificate of occuracy accompanies each. While it might be well to disinfect the needles and syringe before using, by syringing them with a 4 per cent. carbolic water, I have found that there is but little danger in private practice even if this precaution is not observed. The gluteal regions are said not to be very suitable for these injections.

In the use of the gray oil it has been my practice to inject 0.1 c.cm. every week for the first four to six weeks. Usually macular eruptions fade after the second or third injection, papular ones after the fourth or fifth. Examination of the urine showed the presence of mercury within the first week, and its presence was noted for a month and more after all injections had been stopped. The injections of smaller quantities (0.1 c.cm. of the 30 per cent. oil) in different parts of the back are of greater advantage than the injection of double the amount in one place, the urine showing the mercury sooner in the first case than in the second. The only precaution to be observed in the employment of the gray oil is not to use too much. It is a frequent temptation when the curative process is slow to increase the amount injected or to repeat it oftener. This is to be avoided, as the mercury is only slowly converted and accumulates to the point when it manifests its potency over the syphilitic process. Another precaution to be observed is to pay careful attention to the teeth and mouth. As the development of absorbable mercurial compounds is progressive the injections should be discontinued or made less, even upon the slightest effect noticed on the gums. This medication is a most effective and potent one, and I can readily see how, by lack of precaution, severe salivation might ensue. Let no one suppose that, as there is little reaction immediately upon the injection, it might be pushed without hesitation. The literature has several cases where an uncalled-for free use of this remedy has caused not only bad but also fatal results. In my experience such has not been the case, although I have employed it with uniformly happy results in a large number of cases.

To sum up the indications for the hypodermatic medication of syphilis, I should say that in cases where the symptoms require urgency of treatment I would employ the injection of a one-fourth grain of corrosive sublimate, at first daily and subsequently every other day until about twenty-five injections had been given. If, after this, all the symptoms have not entirely subsided (entire absence of all pigmentation) I should resort to injec-

tions of the 30 per cent. gray oil, 0.1 c.cm. in one or two places in the back once a week until six to eight injections have been made. If, after a shorter or longer period without medication, further manifestations of syphilis should appear, the same series of injections with gray oil should be made and thus continued until, after long lapses between treatment, no further return of the lesions appears. The injections of corrosive sublimate, as described, have the advantage of more rapid action, and will often suffice. I should always recommend their use at first as preferable to others, but when relapses occur the injections of gray oil are both less painful and promise greater immunity from subsequent relapses.

MOTOR DISTURBANCES IN THE DISEASES OF CHILDREN.

A. W. WILMARTH, M. D.†

In this brief paper I have endeavored to condense from the voluminous and scattered literature on nervous disease in children, a few practical points which may be of service in the diagnosis and prognosis of such cases, as we meet them in every day practice.

Gowers, Bramwell, Osler, Sachs, McNutt, Buzzard and others have written at length on this class of disease, and it is from their writings I have drawn largely the material for this paper, adding a little from my own experience among cases of juvenile nervous disease.

The most significant symptoms of irritative or destructive changes in the nervous system of the young, are disturbances of the muscular system as evidenced by paralysis or convulsions, in changes in the electric and so-called reflex reactions. Convulsion is perhaps the most frequent form of expression of nervous irritability. It varies greatly in frequency and form. As the protest of the nervous system against an irritation, seemingly beyond its power of endurance, from the teasing irritation of an erupting tooth in the dentition of infancy, or the poison of one of the specific fevers, we are accustomed to see spasm result and are not liable to be greatly alarmed by its occurrence. When the immediate cause of irritation has seemingly disappeared and the occasional spasm still re-occurs at longer or shorter intervals, the questions at once confront us: When and what is the cause of this trouble? What is the probability of ultimate recovery?

That well-marked epileptic spasm, continuing for a considerable period, may occasionally result from continued peripheral irritation, such as optical defects, nasal polypi, etc., to disappear with the removal of the local cause, seems to be proved by abundant clinical testimony. That they arise from such causes nearly so often as some specialists would have us believe, may well be doubted. But such causes are operative so often that we should never fail to look for them, if possible, before falling back on the habitual use of bromides or other routine treatment. Such spasms may be expected to be general in character, and may coincide with increased pain or irritation in the diseased parts.

There is nothing in the ordinary general convulsion to require more than passing notice, but in the period of their occurrence and in the location of the so-called Jacksonian epilepsy, there is valuable information to be gained. In a recent publication I have given reasons in full for believing that when in epilepsy, aside from exciting causes of a temporary nature, convulsions show a tendency to return at regular intervals—say every 4th, 10th, or 14th day, or other definite period, —there is generally, in fact almost invariably, a definite organic lesion of the brain whose constant irritation finds expression through these regular explosions of nerve force. Permanent recovery in such cases can rarely be looked for.

Cases of Jacksonian epilepsy form an interesting study, for in them we can definitely locate the seat of irritation and enable the surgeon in suitable cases to cut down and remove the cause of mischief. Without going into detail, in this interest-

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ing form of spasmodic trouble, I will cite one typical case.

L. D., aged 16, walked into the office one day from his room near by, dazed and frightened, but able to find his way along. All the muscles on the right side of his face supplied by the seventh nerve were in a condition of rapid, clonic spasm. No other muscles were implicated. After about a minute's time this ceased, and the heavy breathing and tendency to sleep followed as in ordinary general convulsion, but not to the same degree. Occasionally, in this boy, the convulsion becomes severe and general, but always originates in this group of muscles. This case in its earlier stages would probably have been benefitted by operation; but now mental decadence indicates diffused cerebral changes.

The minor form of epilepsy, *petit mal*, is multiform in its phenomena and grave in its significance. It is generally indicative of beginning change in the intracranial organs, and unless early and vigorous treatment is begun, this will almost surely end in mental failure. It is liable to be overlooked in children; or if noticed, to escape treatment on account of its apparent insignificance. When met, it is not to be cured by "worm powders," though the family be ever so sure that these parasites are present; nor yet checked by large doses of bromides, for the attacks of themselves do little harm and may be our only indication of cerebral trouble; but every medical and hygienic measure should be employed to build up the brain to resist the destructive process that threatens it. I have notes of one case of a rare form of this disorder.

Chas. D., born 1880; father and mother both drunkards; the latter subject to violent fits of rage during this pregnancy, and below average intelligence. Child is strong, well formed, but mute. An unexpected light touch on the top of his head and he will fall to the ground as if struck down with a club. Rises immediately, looking pale and dazed, and regains full consciousness at once. If he sees your intention before he is touched, no effect follows. Hughlings Jackson describes one similar case. I have seen no others recorded. This peculiarity disappeared in time and well marked Jacksonian epilepsy followed.

One more clinical picture of convulsion will, perhaps, be of interest.

A child is found in a long series of convulsions, more generally of the Jacksonian type. Mild fever; convulsions usually short and not severe; period of unconciousness bridging the intervals between the spasms. These may last several hours, but more frequently a day or two, when, if the child does not die of exhaustion, some recovery takes place. I say *some* recovery, for the evidences of intra-cranial mischief are very apparent. If paralysis results, it will be complete and permanent. If the motor region escapes and other portions of the brain are attacked, the sensory or mental loss will be equally apparent. This is the effect of the so-called tuberous or hypertrophic sclerosis.

Convulsive attacks during the eruptive fevers may stimulate this condition, but they are of shorter duration, the spasm more severe, the stupor more profound, and the prognosis far more hopeful. I have used the term "Jacksonian epilepsy" in rather a broad sense. It is generally asserted that in this type consciousness is retained, but in nearly 400 cases of epilepsy of which I have had the care, I have yet to see a case in which consciousness was not in some degree, however slightly, affected.

Another frequent symptom of interference with functional activity or of actual organic change in the nervous system, is paralysis. This may exist at birth or may develop at any later period, and by its method of development in conjunction with other evidence of imperfect action in the nervous mechanism, may throw considerable light on the location and sometimes on the nature of the lesion of which it is a symptom. Paralysis at birth may be due to non-development, to intra-uterine disease or to injury during delivery. An easy birth would exclude the latter cause.

Correct diagnosis is of importance in our judgment of the future of the case, for while Gowers asserts that in nearly all cases of birth palsy, when absolute idiocy does not result, some improvement follows. I am certain when the cause, be it disease or non-development, antedates delivery, marked improvement *rarely* occurs. In these cases, paralysis of non-development are usually of the flaccid variety. While more or less rigidity and generally complicating epilepsy, marks early sclerotic change resulting from fœtal or early infantile disease. One point should never

be lost sight of in any case where serious disease or injury has occurred in the upper brain in early infancy. That is, that mental development will very generally be checked or destroyed, and feeble-mindedness result. We have only to remember that competent judges place the number of this short-lived class, in this State alone, at nearly 9000, to realize how many minds are ruined by infantile disease each year.

The causes, nature and locality of the lesion in the paralysis of early childhood are better understood than in the congenital types. The more usual forms are commonly traced to one of three causes: 1, Result of infectious disease. 2, Anterior poliomyelitis or acute infantile spinal paralysis. 3, Cerebral lesion.

The first variety is often seen as a complication or sequel of diphtheria; or less often, of typhoid fever or pneumonia. It may appear in malarial fever. It is generally looked upon as the result on the peripheral nerves of the specific poison, and is the least grave of the three general forms. Its diagnosis is usually made clear by the accompanying symptoms.

Where paralysis results from disease of the nerve cells of the anterior horn of the spinal cord (constituting acute infantile spinal paralysis), it is heralded by considerable fever, rarely with convulsions, and may involve the muscular system quite extensively. The paralysis very rapidly reaches its highest degree, is followed by rapid wasting of the muscles, affection of the reflexes and diminution of faradic excitability. Bramwell states that fibrillary twitchings are often seen in these cases. It is often paraplegic, sometimes monoplegic, very rarely hemiplegic. Cerebral paralysis, on the contrary, is generally ushered in by convulsions, is most frequently hemiplegic. The most positive diagnostic test as to where the paralysis originates, is by the use of the galvanic and faradic currents. In anterior poliomyelitis, the excitability of the muscle to the faradic current soon disappears, and the slow but strong response to the galvanic current, known as the reaction of degeneration (R. D.), develops. Dr. Buzzard states that the faradic excitability may disappear entirely within a week, and the principle diagnostic sign of R. D. develop. This reaction does not exist in true cerebral palsy. Authors lay great stress on this symptom, not only for its diagnostic value, but also for its significance in prognosis. Miller and Duchenne state that muscles in which faradic excitability has entirely disappeared in four or five days, are permanently paralyzed. In those in which some excitability remains after the tenth or twelfth day, motility may be expected to return even though some months may be required. Buzzard entertains an even more hopeful view, especially when the loss of faradic excitability is slow. The loss of galvanic excitability is of grave import. Bartholow sums up these reactions as follows: When a child having one or more members paralyzed as a consequence of an anterior poliomyelitis is brought to you for treatment, you may promise much if the muscles react to the faradic current, however slightly. Be reserved if they react only to the galvanic current. Promise nothing when neither current causes the least movement. Paralysis may be present in spinal pachy-meningitis. Pain on movement and anæsthesia will help clear the diagnosis in such cases.

I think those few diagnostic points would be sufficient in most cases to distinguish the seat of origin of juvenile paralysis and so to select its treatment. In giving our opinion of the outcome of a case we should not forget that the age of onset has an important bearing in cerebral palsies. Osler states that the younger the child, the greater the liability to serious and permanent damage. The reverse holds true in epilepsy.

On the subject of the reflexes, we will consider at length only two, the patella reflex and the ankle clonus, and in dealing with them will quote some conclusions from the writings of Drs. Remak and Ziehen. In testing these reflexes in children we should exclude post-febrile paralysis and recent convulsions, both of which may decidedly influence them.

Unilateral exaggeration of patella reflex is always significant of disease. Bilateral is only significant when ankle clonus co-exists.

Ankle clonus may be physiological in children. Diminished plantar reflex with exaggerated knee jerk signifies functional and not organic disease.

Ankle clonus has the same relation to the lateral columns as Westphal's symptom has to the posterior columns. In

ordinary apoplexy with loss of consciousness, a primary foot clonus develops, which shortly disappears. If, in from two weeks to two months, ankle clonus reappears in the paralyzed limb it means secondary degeneration of the lateral columns and a certain anticipation of permanent contracture.

Unilateral ankle clonus in hemiplegia indicates a central lesion and almost always excludes a spinal affection.

The maintenance of patella reflex in spite of partial R. D., occurs probably only in polio-myelitis anterior. (*a*) The loss of patella reflex generally follows all cases of severe paralysis with relaxation of muscles, and diminished irritability of the nerves, whether of spinal or peripheral origin, and in case of recovery, this lasts longer than R. D. (*b*) Patella reflex fails in peripheral neuritis of mixed nerves. (*c*) Also fails in complete peripheral paralysis when there is no R. D.

In conclusion, I would say that in all cases where patella reflex fails in children, we should never fail to examine the spine in the dorsal and lumbar regions for evidence of Pott's disease with secondary inplication of the cord.

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THE PRESENT STATUS OF CORROSIVE SUBLIMATE IN SURGERY.*

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I want to say a few words on a subject in which we are all inte rested—the present status of corrosive sublimate in surgery. For a long time all of us who work in general surgery have wondered why we failed to get good results in cases where we thought we had done everything that could be done to assure an antiseptic condition of the part. Two years ago I ceased the use of solutions particularly in fresh wounds, and have lately ceased to use them at all, even in suppurating conditions. Three years ago Welch, of the Johns-Hopkins University, made a report in which he mentioned numerous experiments with sublimate to find out something about the action and power of this drug. He has given us reasons why we often times fail in getting an aseptic condition or have an aseptic outcome of a wound from the use of this substance. It has been proven that the inhibiting power of bichloride of mercury is just so much, which is in proportion to the albuminous material it has to deal with. I think it is proven beyond all doubt by his experiments and by those of his assistants, particularly Abbott, that the present position of bichloride is rather against its use, and that it does more harm than good. If the solution be of sufficient strength to have any effect upon germs already there, it will cause necrosis and prevent healing of the wound, as well as producing a better nidus for the production and operation of other micro-organisms.

I will read from Dr. Abbott's paper, his conclusions upon this subject which may be of interest:

"What conclusions are we justified in drawing from such results as those obtained in the experiments here reported?

(1), It is seen that under the most favorable conditions a given amount of sublimate has the property of rendering inert only a certain number of individual organisms. That is to say the process is a definite chemical one taking place between the protoplasm of the individual bacteria and the sublimate in solution.

(2), That the disinfecting activity of the sublimate against organisms is profoundly influenced by the proportion of albuminous material contained in the medium in which the bacteria are present.

(3), That the relation between the golden pyogenic staphylococci and sublimate is not a constant one, organisms

* Read before the Medico-Chirurgical Society of Louisville, Feb. 17th, 1893.

from different sources and of different ages behaving differently when exposed to the same amount of the disinfectant for the same length of time.

(4), That the organisms which survive the exposure to the sublimate may experience a temporary attenuation. This attenuation, however, may be caused to disappear by successive cultivation in normal media.

(5), That by the method employed in these experiments, it is possible to select from a culture the most resistant forms in that culture.

(6), That many of the results of previous experimenters, who have assigned to corrosive sublimate more powerful disinfectant properties against the staphylococcus pyogenes aureus in cultures than the observations reported in this paper indicate, are attributable to the neglect of certain precautions now recognized as essential to the proper conduct of such experiments."

"In the light of these experiments and those of the experimenters quoted in this paper, it is plain that for use in surgical practice the solutions of corrosive sublimate do not possess all the advantages hitherto attributed to them.

"To the employment of sublimate solutions upon wound-surfaces it is plain that there exist at least two serious objections:

First, the albumen of the tissues and fluids of the body tends to diminish the strength of, or indeed renders entirely inert the solution employed.

And second, the integrity of the tissues is materially injured by the application of solutions of this salt."

"The first objection cannot be met with certainty, for the surgeon possesses no means by which he can determine the albuminous material with which his solutions are to come in contact, and in any case this large amount of albuminous material is an almost insuperable obstacle to complete disinfection with sublimate. He is, therefore, never in a position to say, *a priori*, that his efforts at disinfection of the wound are, or are not, successful."

"The second objection is equally serious. During the past two years we have had sufficient evidence to lead us to believe that the normal tissues and fluids of the body possess the power of rendering inert many kinds of organisms which may have gained access to them. This function is, therefore, diminished, or, indeed, may be quite destroyed, by any agent which brings about alterations in the constitution of these tissues. We know that just such changes as those to which we refer, are known to follow the application of sublimate solutions. It is plain that if we bring about in these tissues a condition of superficial necrosis—the condition following upon the application of sublimate—they are much less able to resist the inroads of infectious organisms than they would have been had they been left in their natural condition."

"As a disinfectant in the strict sense of the word, there are perhaps few substances which possess the property in a higher degree than does corrosive sublimate, but at the same time there is nothing which is employed for this purpose, that requires greater care in its manipulation in order to obtain its best results, than does this salt. As we have seen, its action is influenced by a number of conditions which in practical application it is difficult if not quite impossible, to control."

"For these reasons we seem hardly justified in continuing to give to it the first place in the list of substances which may be employed practically for the purpose of rendering harmless, materials containing the germs of infectious maladies."

I have found in my practical work. that since I ceased the use of sublimate solutions I have had much more uniformly good results by using simply sterilized water.

A case of failure of orificial methods has been reported in the *Jour. of Orificial Sur.* for November. A man was afflicted with impotency (variety and supposed cause not given). "All-round orificial work was done, including the American operation, circumcision, and removal of a portion of the scrotum; yet after a year no relief is reported." Why portions of the penis, testicle and vas deferens were not removed, is not stated.

A Dressing for Cuts, Sores, Scalds, Etc., Is made by boiling together 1 pound of resin and 3 ounces of clarified beef suet; then add 2 ounces of beeswax, boil one-half hour longer and allow to cool.—*Ex.*

IMPROVISED SPLINTS FOR FRACTURED LIMBS IN CASES OF EMERGENCY.

A. O. SIMPSON, M. D., Thompson, Pa.

In spite of the rapid strides that surgical science has made in our day and the great improvements in the art of treatment, emergencies do arise that tax the mechanical ingenuity of the surgeon to cope with. As an illustration in point I will cite a couple of cases:

I. On the 15th of July, 1888, while returning home from a neighboring town, I was stopped on the road and told that a Hungarian had broken his leg while wrestling. On going into the house I found a muscular railroad workingman lying on the bed with a broken leg. Both bones were broken about three inches above the ankle, the fracture being an oblique one and simple. I could not find any pasteboard in the house nor had I any splints or apparatus with me. I did however, have in my medicine case a small roller bandage and some adhesive plaster and chloroform. I administered a small quantity of chloroform; adjusted the broken bones; placed four strips about five inches long and one inch wide longitudually over seat of fracture; wound a strip of adhesive plaster spirally around the leg, over the longitudinal strips; over that I wound about two yards of muslin bandage, fastened it with needle and thread; placed the broken limb on a soft pillow, and then went in quest of a splint. Not far from the house I had seen some small second growth maple trees. I took a sharp ax with me, selected a tree of about the size of the lower part of the leg, girdled the tree and removed the bark from it in a section about ten inches in length. Then I went back to the house, tore up a piece of an old bed quilt, padded my splint and, after trimming it to proper shape with my knife, adjusted it to the limb and confined it there with three strips of bandage tied around and over the splint.

I did not see the man again for several days, but told him and his fellow workmen not to attempt to use the limb or to disturb the splint or bandages without my knowledge. Three or four days afterward I saw him and removed the splint and bandages. The ends of the bones were perfectly adjusted, and the cotton batting and improvised splint had moulded themselves to the shape of the limb. I reapplied the apparatus and told them to let the splints and bandages remain on for three weeks more, but that he might walk around the house with the aid of a crutch. At the end of the fourth week after the accident he discarded the splint and crutch and went to work again, using a cane to walk to and fro, as the leg was a little lame and stiff for about a week more. At the end of the fifth week there was no stiffness or lameness in the limb and the patient was perfectly sound.

II. R. T. (a blacksmith by occupation), on the 29th of June, 1892, while assisting in raising new bents on a barn, lost his balance, fell and fractured his leg near the ankle; from the fact of striking "terra firma" on his feet he fractured both bones. As he fell about twenty feet there was a compound fracture. I went to see him in the night but did not take any splints with me. Remembering my recent experience with the Hungarian, I did not feel in the least disturbed. I adjusted the fractured bones without chloroform, but using adhesive plaster, to retain fractured bones in apposition. Then I went into the woods near by and peeled a maple tree of proper size as in the previous case; trimmed off sharp corners of the bark splint with my knife; adjusted the splint to the limb with cotton batting; wound a muslin bandage over the splint with moderate tightness and strung up the limb by means of an iron pulley wheel screwed into the ceiling over his bed. By means of a cord attached to bandages around the limb and passed over the iron pulley, he could change the position of the limb "ad libitum." The well-padded maple bark splint proved a valuable mechanical and antiseptic appliance, as no change was ever made afterwards.

At the end of five weeks the splints were removed altogether. One week after the accident he was allowed to walk around the house with the aid of a crutch.

In neither of the cases mentioned here were any dry or moist applications used. From my own experience in such cases I have come to the conclusion that nature will do more toward the process of repair in case of fractured bones than art can do. All that the surgeon can do in such cases is to favor the effort of nature toward repair, by retaining the broken ends of bones in apposition.

SOCIETY REPORTS.

PHILADELPHIA COUNTY MEDICAL SOCETY

Meeting of March 8th, 1893.

DISCUSSION.

Dr. Wolff's paper on Hypodermatic Medication in Syphilis. (See page 525.)

Dr. J. William White: There are some points in the paper which attracted my attention, although I make mention of them chiefly to disagree. The reader stated in one of the opening paragraphs of his paper that in the principal medical centres of Europe little or no mercury was given by the mouth, the inference being that in this respect we are behind the times. As a matter of fact, if we look over the present treatment of syphilis in the hands of the most distinguished men of the profession who have made syphilis a specialty, we shall see that the reverse of this statement is true, and that comparatively little is given hypodermatically. In Germany some of the best men have pronounced against it as the method of choice, although there it prevailed to a great extent. In France even the veteran Fournier has pronounced against the routine use of the hypodermatic method. In Great Britian, Jonathan Hutchinson finds no reason in his experience for the use of this method. In this country, Taylor and Keys, of New York; Bryson, of St. Louis, and specialists in all parts of the country are reserving the employment of this method for rare cases. I would, therefore, take issue with the statement that in the principal medical centres of Europe this is the method of choice.

Another point which attracted my attention was the extraordinary quality that his patients seem to possess of preferring this method of treatment. This is absolutely the reverse of the experience of everybody else who has put himself on record. Fournier has called attention to the fact that while you may cause a rapid disappearance of the disease, you also cause a rapid disappearance of the patient. Every French syphilographer, who has recently written, has emphasized this point with the exception of two or three enthusiasts who are still carrying on experiments in this direction.

The remarks in regard to the effect of the treatment on open sores, would seem to indicate that Dr. Wolff began the treatment very early. If the rule, not to begin treatment until constitutional symptoms are manifested, were adopted, it might change his percentages. His statistics are open to the imputation that the cases were not all cases of syphilis, on account of the fact that there is a considerable proportion of "sore" which it is impossible to diagnose, unless constitutional symptoms are waited for.

Dr. Wolff gives twenty-five to thirty injections, and then stops the treatment. That seems the most defective feature in the method. It has been claimed that the disease is cured by thirty-five injections, each of a quarter of a grain of corrosive sublimate, the treatment lasting a little over a month, a little less than nine grains of mercury being given. If this is true, we have to suppose that there is some virtue about mercury given in this way which it does not possess when administered in other ways. The evidence is steadily accumulating that it does not produce permanent cures and that it is attended by a larger number of relapses than other methods, and the claim that thirty or forty injections of a soluble preparation of mercury or five or six of an insoluble preparation will produce a

cure of syphilis, is without foundation. Dr. Wolff spoke of the liability to relapse, and I can readily understand this if he stops at the end of the thirty-five injections. If he had only forty per cent. of relapses, he was fortunate.

As to the insoluble preparation, calomel, which Dr. Wolff places first, is first in order of time, as it was introduced in 1864, and revived seven or ten years ago by Smirnoff, a Russian physician, and has, until a few years ago, kept its place. It has, however, been supplanted by the yellow oxide, which is now used more than any other insoluble preparation. The objection to this plan is that it is only another way of giving a soluble salt. The insoluble salt is slowly converted into a soluble form, and, so far as I understand the matter, this becomes one of the most inaccurate methods of giving mercury. One of the claims put forward for this method is that it insures scientific accuracy. Anything more unscientific, as regards precision of dose, than to throw under the skin an emulsion of metallic mercury in lanolin or a quantity of calomel or yellow oxide, and allow it to remain there, subject to the vicissitudes of different degrees of inflammatory action attended with different degrees of absorption, would be hard to imagine.

As to the freedom from harmful consequences, as a matter of fact you have in some patients, as a direct result of this treatment, a violent stomatitis, dangerous salivation, entero-colitis with bloody stools, and where vaseline or fatty preparations are used, pulmonary embolism. There are on record fatal cases from these sources. Occasionally the metallic mercury remains under the skin inert for a time, and then suddenly becomes absorbed in large quantities, with the development of violent symptoms.

These objections are founded upon the observations of men who were advocates of the method, and who have had the frankness to record their unfavorable cases, and cannot be disputed. Autopsis in cases where the insoluble salts have been administered experimentally in other diseases, show that there is great variability in the rapidity of absorption.

The pain is severe and belongs to every mercurial salt administered in this way. Lang's statement in regard to the absence of pain and other symptoms after the administration of the gray oil, is contradicted by other observers. In the best hands there has been a certain per centage of abscesses, and although the introduction of antiseptic methods has reduced their number, they are occasionally inevitable. Far more frequent are the painful nodosities about the seat of the injection.

The conditions under which the method should be employed are extremely limited. I believe that it should be held in reserve for cases where other methods have failed. Given a patient whose gastro-intestinal tract reacts to mercury in such a way that the various preparations become irritants, and in whom the use of inunctions produces a violent dermatitis or mercurial erythema, and such a case would suggest a trial of the hypodermatic method. In grave emergencies, such as the serious eye-troubles of the secondary stage, it might even be regarded upon an equal basis with inunctions. There is no evidence to show that it is of greater value. If you want to produce rapid mercurialization, the administration of small doses of the protiodide, calomel or mercury and chalk, supplemented by the simultaneous inunction of mercurial ointment, will almost equal in rapidity the use of the soluble salts of mercury. I think that everyone will admit that in the presence of threatened grave complications, the hypodermatic method might be suggested. In old syphilis, mercury does not take the place of iodide of potassium. If you have a gummatous meningitis, or an infiltrating gumma of the brain, or a periostitis in the late stages of syphilis, or if you have any of the tertiary phenomena, while mercury hypodermatically might be useful it should be regarded only as a valuable adjuvant, but secondary to the use of the iodide of potassium.

I think that this subject is well worth discussing, and I am extremely glad that Dr. Wolff has read this paper. I came to hear it, and to put myself on record in relation to the whole question. I think that in what I have said I have spoken the views of the majority of syphilographers.

Dr. Richard A. Cleeman: I have used the hypodermatic method, and I think that Dr. White is a little severe. I have had several patients who prefer it very much to mercury by the mouth. I

have used more than thirty-five consecutive injections, and have given as much as one-third of a grain at a time, giving two injections of one-sixth of a grain each. I have never had abscess, but I have seen the painful nodosities, and once I had to stop because the parts were so painful that the patient was not willing to continue the treatment. After the nodosities disappeared, he came back and the treatment was resumed.

I have found, contrary to what has been said in the books, that a small quantity of corrosive sublimate will not remove the symptoms, particularly in cases of tuberculous skin disease in the form complicated with ulceration. You have to use many injections before any effect on the ulceration is produced. Finally, the ulcerations disappear as a rule. The great advantage of the use of injections is that you overcome the great tediousness of the ordinary treatment and the liability of the production of digestive disturbances. In a case I have in mind the man was in splendid general health while the hypodermatic method was used, but when mercury was used by the mouth he suffered from diarrhœa and troubles with stomach.

I have not used injections in the primary stage of syphilis, but in one case I have used them immediately on the appearance of the secondary symptoms. After the use of twelve injections the symptoms disappeared, but they reappeared in the course of a month in a rather unusual form—that of thickening of the nails. I am now using injections in this case. The general health is excellent, although he was much run down before; he is much pleased with the method. The pain, while it is sometimes severe, is not unbearable.

Dr. J. A. Cantrell: Contrary to the experience of Dr. White, I must say that the hypodermatic treatment of syphilis will cure in most of the cases. I have seen forty or fifty cases where the treatment has been continued up to thirty or thirty-five injections, and where the patients have not come back for the treatment of the disease. I have seen one of these cases seven years after the treatment, and there had been no return of the disease. I have, however, seen cases where the injections have been continued until as many as sixty or even one hundred and twenty had been given without benefit. Fournier has, I believe, within a month injected for macular syphiloderm. Sometimes the injections are not absorbed for a week or ten days, and often leave decided ulceration. In the cases in which I have seen the method employed, I think it would have been better to have used internal treatment, and if the cases did not do well the hypodermatic method might have been tried.

Dr. Edwin Rosenthal: I have used the hypodermatic injections of corrosive sublimate quite a number of times. I think that Dr. White is too severe in his denunciation of this method of treating syphilis. Practical experience has demonstrated its utility and the many advantages it has over other methods. The inuction method for instance, is the dirtiest that can be employed, and will drive away more patients than the hypodermatic method will. One of the points in favor of the latter method is that the patient has nothing to do with the treatment, but eat and drink whilst undergoing a cure. The injections are cleanly, devoid of all risk when judiciously made; at first they are made daily, and afterward every second or third day.

I have given the injections in the primary disease, in a case of chancre of the tongue, in which the lymphatic glands in the cervical region were very much enlarged, and where the internal administration of remedies could not be borne by the patient, and prompt treatment was indicated, with very good results. This patient is still under treatment, but there has been no appearance of an eruption.

Speaking of the large dosage given at a single injection and its good results, I wish to record another point, and that is: In infantile syphilis the dose of $\frac{1}{200}$ or $\frac{1}{100}$ grain of corrosive sublimate, as recommended by Dr. Jacobi (*Journal of Pediætrics*), is too small. I have seen a vast number of cases of infantile syphilis, and have lost quite a number, until I increased my dosage; and I never begin with less than $\frac{1}{60}$ grain of corrosive sublimate, and gradually increase the dose.

Dr. Charles Wirgman: A point to be borne in mind, both in private and hospital practice, is that as soon as the lesions disappear the patient ceases to return for treatment. No matter how eloquent you may be in regard to the neces-

sity of continuing treatment, they disappear. If it could be demonstrated by a more extensive use of this method that 35, 75, or even 175 injections will take the place of two or three years' treatment, that would be a great boon to humanity, and the question is worthy of serious consideration and further trial.

Dr. S. Solis-Cohen: The discussion points to the fact that it would be well to elicit further testimony as to the time when a syphilitic patient can be considered "cured." My own experience has been so largely with late lesions, occurring in cases that have been treated by many different methods, and in which quite a number of years has elapsed since the primary infection, that I am compelled to consider it at least premature, because symptoms may have disappeared for a time, to say that the treatment has cured the disease. The patient must, it seems to me, be kept under observation for a prolonged period, before we can record even a probable cure or recovery; and this is the fatal defect of all methods which limit themselves to a comparatively brief period during the time of early symptoms. My personal use of hypodermatic injections of mercury in syphilis has been limited to the employment of corrosive sublimate for rapid effect in early or late cases, so that I am unable to discuss the other methods, except from a theoretical standpoint; and therein I am entirely in accord with Dr. White. In the extreme cases of late lesions I sometimes meet, I resort preferably to inunction, associated with or followed quickly by internal use of potassium iodide in ascending doses; and acting upon a suggestion of Bartholow's, I sometimes conjoin with this the steam bath and the hypodermatic use of pilocarpine, to hasten elimination. It is dangerous to push the action of tissue-destructives unless we provide for rapid elimination. Hence the advantage, too, of giving large draughts of water or milk with potassium iodide.

Dr. Joseph Hearn: I have used the hypodermatic method in only one case where the stomach was irritable Under treatment of one-eighth of a grain doses the patient improved. I think that it is a method which should be held in reserve. There are cases which cannot bear the iodides. I have been taught that the iodides do not cure syphilis, but rather its consequences. Only mercury cures syphilis. If I am in a hurry, I use inunctions, but if there is no urgency I use internal treatment. I cannot say how many of my cases are cured. I believe that the disease can be put in abeyance so that the patient will live any length of time.

I would like to ask if the administration of mercury during the primary stage will mask the secondary symptoms so that you cannot recognize them.

Dr. James Mitchell: We have patients with syphilis where the disease appears to have taken a mild form. I have used all forms of treatment with the exception of the hypodermatic. My experiences of late years has been principally with the secondary and tertiary affections, particularly of the eye. I find that sometimes the patient deny anything like infection. I think that when we come to a study of the treatment of any disease we must take into consideration the fact that all diseases vary in their intensity in different individuals. And I think that this is the reason that we have different results with the same treatment, and why one method of treatment will fail while another will effect a cure.

Dr. John B. Deaver: My experience with the hypodermatic administration of mercury is comparatively limited. I have not used it sufficiently to say much in its favor. Of course, one of the objections is the decided pain which it causes. Painful indurations have been marked in some cases and have been some time in disappearing. I have, however, seen most excellent results obtained in ulcerative conditions of the pharynx and soft palate, where the internal administration of mercury did not suffice, largely, perhaps, because it excited irritation of the digestive tract, and where inunction had also failed.

One of the weakest arguments against the use of injections is that a cure is produced in so short a time. I believe that many of the cases of early relapse are due to the fact that the physician has been led to believe that he has cured the case. From my observation, I think that treatment should be prolonged for four years, or, at least, three years. I have had sufficient satisfaction with the ordinary treatment not to resort to the hypodermatic method, except in special cases.

Dr. White: In reply to the question

of Dr. Hearn, I would say that I believe that the prompt administration of mercury in primary syphilis will prevent the appearance of the secondary symptoms. I used to think to the contrary, but observation, experience and reading have led me to change my views.

I know of no test which can be applied to the individual which will demonstrate the presence or absence of active syphilis. I believe that 90 to 95 per cent. of the cases can be cured, but it is impossible to say at the beginning which of the cases will not be cured. As a matter of fact, syphilis is inclined to be a self-limited disease. Nothing but the experience of years will demonstrate the possible cure. The point has already been made in regard to relapses, and I think that figures are accumulating that are distinctly against the method, and will show that the proportion of relapses with the hypodermatic method is greater than under the classical methods which we have been using.

Dr. Drake: I have recently returned from Europe. For six months I was Kapsoi's assistant. In most of his cases he uses the hypodermatic method, the injection being made in the gluteal region once a week. Neuman, of Vienna, uses the salicylate of mercury hypodermatically. He also uses internal treatment in some cases. Lang, of Vienna, is at the present time experimenting with the gray oil. Lukasiewicz also uses injections of a five per cent. corrosive sublimate solution, a gramme every week.

In Berlin, the dermatologists and syphilographers, Joseph and Lassar, use hypodermatic injections in most of their cases. In some, they use inunction.

In Paris, Fournier was using hypodermatic injections at the time that I left. In some cases there, after the first injection the eruption entirely disappeared. Of course, it was a little painful, but it did not occasion the patients much trouble, and they gladly submitted to the treatment, and preferred the hypodermatic injections.

Dr. Wolff: As stated in my paper, I have made thousands of injections, and the patients whom I have taken off the hypodermatic method and given protiodide by the mouth, have asked to have the former method resumed. They did not seem to mind the pain very much.

In regard to the administration of the remedy before the diagnosis was established, I would state that the injections were not made until the muscular eruptions and other characteristic symptoms had manifested themselves. I never treat constitutionally for the primary sore alone.

As to the results, I stated that I have found no return of the symptoms in sixty per cent. of the cases. I do not know whether or not these gentlemen can tell syphilis when there are no symptoms. Syphilis is only present, in my opinion, when there are symptoms. The duration of the treatment has been, on an average, twenty-five injections, and I am not the only one who makes that statement. Many thousands of cases have been treated at the Charitè in Berlin.

Kaposi led the discussion on the therapeutics for syphilis, at the Congress für innere Medizin in Wiesbaden, 1887, and it was generally accepted for the principal methods of treatment and the relative permanency of their results, as follows: the inunction method, most permanent; the calomel injection treatment next, and the hypodermatic injection of corrosive sublimate, as third. It was stated elsewhere that the permanent results of the first were 75 per cent.; the second 70 per cent.; the latter, 65 per cent. My results have not been so good, although I injected larger doses and for a longer time.

In regard to the time of cure. This may be said to be obtained when there is no return of symptoms. There is no such thing as saying that syphilis will be extinct after two or after four years. I have seen it return after twenty years, in spite of treatment. There is only extinction when there is no return of symptoms. To limit it to any one time is almost out of the question, because the time of cure for syphilis cannot be predicted.

I have given my paper as the result of personal experience. If mistakes have been made, they have been the result of misinterpretation and lack of a sufficient number of cases, rather than a want of truthful statement.

Post-partum Uterine Pains.—(Treatment.)

[Rutherford—*Rev. Gen. de Cl. et de Ther.*]

℞ Quinine Sulphate.....1.0 gms. [15 grs.]
Opium.....0.5 gms. [7½ grs.]
Buckbean Extract..... q. s.

Divide into 15 pills. One every 2–3 hours.

THE MEDICO-CHIRURGICAL SOCIETY OF LOUISVILLE.

Stated Meeting February 17th, 1893.

Dr. F. C. Simpson, President, in the Chair.

ANEURISM OF CHEEK—OPERATION.

Dr. W. O. Roberts: This patient was before the society last summer and is a patient referred to me by Dr. Turner Anderson. You will doubtless remember the case as one of circumscribed aneurism resulting from injury to the face by a blow on the cheek with a stick. The aneurism had attained a considerable size and the tissues superficial to it were so very thin as to look as though about to burst. On September 8th I operated removing the tumor, and it was with great difficulty that I was able to dissect the skin from the sac of the aneurism. I finally succeeded, but failed however to get union by first intention throughout the whole surface. The girl left the infirmary in two weeks with the wound nearly healed. A week afterward, she noticed in eating that considerable watery fluid would run out of the wound. She came to see me and I found she had, as a result of the little sloughing that took place, a salivary fistula and this continued to discharge up to two or three weeks ago. The treatment was pressure until the wound grew very small, then it was dressed once or twice every day with collodion and iodoform—iodoform dissolved in collodion. Now the discharge has entirely ceased. I thought at one time that I would have to operate on the duct, but with the application of collodion and iodoform the wound entirely healed. There was never any salivary discharge until after suppuration occurred.

SUPPURATION OF PAROTID GLAND.

Dr. S. C. Dabney: I will report two cases of suppuration of the parotid gland, both of which I saw in consultation, the attending physicians thinking that disease of the ear existed. In the first case the first positive information that we had of suppuration of the parotid gland, was discharge of the abscess through its duct into the mouth. There was very considerable swelling, and it came on without any cause whatever that could be ascertained, neither mumps nor any acute disease having preceded. Diagnosis having been made of this trouble, I did not see that it was necessary for me to remain longer. The physician in charge made an incision letting out the pus, and the patient recovered without any further trouble.

No. 2. The second case was very much like the one just reported, except that the face was enormously swollen. She complained of no swelling in the throat, no pain, and no difficulty in swallowing. On looking into the mouth I discovered what appeared to be an immense quinzy, I thought this was very remarkable in view of the fact that there was no difficulty in swallowing and no well-marked pain referred to the throat. An opening was made in the abscess which was just above the left tonsil involving the pharynx and the soft palate. After the incision was made, a large quantity of pus was discharged. I did not see the patient again but was told by the physician in charge that a few days after opening the abscess in the throat, there was distinct evidence of pus on the outside of the face over the lower part of the parotid gland. An incision here gave exit to a large quantity of fetid pus. No communication could be traced from the external opening to that in the throat. The case is unusual, first, because of this external abscess accompanying a quinzy and secondly, because of the entire absence of the pain and difficulty of deglutition and of breathing which usually attend this disease.

DISCUSSION.

Dr. A. M. Vance: Was the gland proper involved or was it peri-adenitis ?

Dr. S. G. Dabney: It seems to me that it was most likely the gland itself from the situation of the swelling. All the symptoms of quinzy were absent so far as the throat was concerned, which seems to me the most remarkable feature of the case.

Dr. A. M. Vance: In connection with the trouble of the cheek, I would like to mention a case that I saw several

years ago, where a razor wound on a negro boy's face in healing evidently obstructed the duct. The external wound healed perfectly, and a large cyst occurred containing about a pint of fluid, the cyst probably destroying the outlet of the duct into the mouth. Dr. Godshaw referred the case to me and I endeavored to produce an opening into the mouth. I finally succeeded by using a slender canula such as is used in dropsy of the legs. I inserted one and let the boy wear it for a month, then removed it and the aperture closed up; I then inserted it again in the previously made opening. Whether it was near the normal one or not I cannot tell, but I finally succeeded in producing, by this small canula, a new duct—I believe it is possible to produce a new duct in this way. Of course I may have been fortunate enough to strike the natural one, simply re-opening it. The boy never had any more trouble after the second insertion.

Dr. W. O. Roberts: In the case reported by me, I thought at one time, as the wound was rather slow in healing, that I would have to carry the duct into the mouth, as is usually done in these cases, closing the external wound. But by the persistent use of collodion it has completely healed, as very frequently happens.

CANCER OF ŒSOPHAGUS; RUPTURE INTO THORACIC CAVITY; DEATH.

Dr. J. B. Marvin: This is a specimen I obtained from a case dying very suddenly at the Baptist Orphan's Home some weeks ago. The patient was a maiden lady about fifty years of age, brought here last summer to consult me, by Dr. Woolfolk, of Owensboro, with the statement that she had some trouble with the gullet, and that the home doctors were undecided whether it was spasmodic stricture, or whether there was an organic stricture, or whether there might be something else to account for the trouble. I left the city in August and turned the case over to Dr. Weidner, who treated her during my absence, the woman growing considerably better. She was one of those pale delicate women; never had been strong; suffered from severe attacks of asthma, etc. When I returned in October, she came back and I saw her at that time; she was able to eat fluids and some solids, and was in every way a great deal better. Dr. Weidner had concluded that it was purely a nervous stricture, spasmodic in character, and had washed the bowels out thoroughly, getting her in good condition, had given her massage, etc. She had quite an attack of trouble with her lungs at that time, and I differed from Dr. Weidner; he thought she had no pulmonary trouble, and I thought she had phthisis. I wrote to Dr. Woolfolk that I believed the result of treatment had proven the trouble was functional or spasmodic stricture of nervous origin. She went home, and after a time returned, looking not quite so well. She had more difficulty in swallowing; some days she could apparently swallow all right, then food would lodge and she would spit it up after a few hours. Bowels had been gotten in much better shape. She had a very unfavorable look, but I made no examination instructing her to resume the rubbing with whiskey and oil, and to take whiskey in small quantities internally. Two days afterward I was summoned very hurriedly, with the statement that she had not been so well the preceding days, had more cough and very free expectoration, and that day had gotten up and was moving about the house. She was eating her dinner when she remarked that she would go to her room on the next floor. About fifteen minutes afterwaad they found her dead on the floor. There had been an evacuation from the bowels and also from the mouth, of a very offensive muco-purulent looking material. I made the autopsy with Dr. Frank and exhibit here the specimens removed.

It was a cancer of the œsophagus which had ruptured into the thoracic cavity. I found in the thorax this little body, which is evidently a sugar coated pill; how long it had been there I do not know. The appearance of the lung indicates clearly that the trouble was not tubercular. Sections of the nodules examined under the microscope prove them to be cancerous. The involvement of the lung was probably secondary.

I certainly made a mistake in the diagnosis, both as to the condition of the gullet as well as that of the lung. It is remarkable the little amount of pain complained of by this patient, when the trouble was so extensive. There is no

history of trauma in the case. I wrote Dr. Woolfolk to give me more information but so far he has failed to do so. This case, I think, illustrates the necessity for more autopsies; without a *post-mortem* it could have been reported, as we see so often now, as dying from "*heart failure.*" Without an autopsy it would have always been a question in my mind as to exactly what she died from; possibly my conclusion would have been that she had a violent coughing spell and the thick, tough sputum had strangled her; however, the *post-mortem* proves that this was not the case.

We know the statements made by some authorities that if there is great emaciation and difficulty in swallowing in patients over fifty years, we should suspect carcinoma or stricture of some kind, but it is equally possible, it seems to me, to have in a neurotic person especially, a spasmodic stricture at any time of life.

Dr. A. M. Vance read a paper (see page 532) on

THE PRESENT STATUS OF CORROSIVE SUBLIMATE IN SURGERY.

DISCUSSION.

Dr. E. R. Palmer: My surgical work is confined almost entirely to minor surgery and yet it enables me to have quite large experience in antisepsis. Take for instance cases like this: A young man working in a tin manufacturing establishment, running machinery that is covered with oil, etc., gets his hand caught and a couple of his fingers are quickly nipped off by the machine; with a dirty, greasy cloth wrapped around it, he is rushed to the nearest doctor's office to have the wound dressed. Now here is a hand that could not be cleansed with sapolio—covered with oil, grit, etc., and it would seem an ideal basis for germ proliferation. The hand was cleansed as well as possible by washing for some minutes with $\frac{1}{2000}$ bichloride solution; the wounds were properly dressed, and there was absolute union of the parts without suppuration. Of course I recognize the value of hot water in cases where it is possible to make the parts absolutely clean and to maintain a condition of cleanliness, but how are we to meet such cases as cannot be cleansed by simply applying hot water; cases demanding a material that acts on oil, etc.; how are we to destroy the germ life that is in such material, in the treatment of such wounds?

I recognize in doing minor surgery that hot water and a solution of boric acid are very useful, and have considerable disinfecting powers, and I use them where it is practicable to make the part absolutely clean before operation. In cases where it is not possible to do this, like the one referred to above, where we have to rely upon something that has positive destructive powers for germs that we can not clean off, I know of nothing better than a sublimate solution.

Dr. D. T. Smith: I am as pleased as surprised to hear from Dr. Vance the views he advances to-night in his essay. Only about a year ago, I was sharply taken to task by him for disapproving of corrosive sublimate as a dressing for wounds. It never was my favorite; I gave it a trial when it first came into vogue, but in the minor surgery which mostly fell to my lot, I conceived that I found it distinctly inferior to the preparation I had been previously using, and so returned to my previous practice. The dressing I have been using from the beginning of my professional career consists of tannin, tincture of opium and claret wine, diluted according to the nature of the case with water. It is practically Burnstead's modification of the French aromatic wine. It is a perfect dressing if the wound be kept constantly moist with it. I have urgently insisted for years, that a substance like corrosive sublimate that forms with the albuminoids a most refractory combination, could not be the proper thing to put between two wounded surfaces with the view of promoting healing. The dressing of laudanum and tannin does not corrode the tissue further than to render them an unsuitable field for bacterial growth, and it does not prevent the surfaces from growing together more perhaps than will the serum itself.

If a tough membrane is formed between wounded surfaces that are expected to unite, it only adds to the task of the leucocytes by whom this substance must be removed; it is these leucocytes after all that afford the protection, much of which has been credited to corrosive sublimate.

And just here, if I may be pardoned the mention, I will venture to claim that I

was one of the first in the field to call attention to this important fact from which Metchnikoff has gained so much honor.

In October, 1884, I read before the Orleans Parish Medical Society an essay entitled "The Role of the Leucocyte," which embraced every leading feature of the doctrine of Metchnikoff relative to the white blood cell. I presented it to the *New Orleans Med. Jour.* and the editor, Dr. Matas, accepted it for a leading article in the next issue. In the meantime a lot of young men got charge of the journal, about eight I believe, and they voted that my article was quite too romantic and fanciful for a scientific publication and returned it to me. I subsequently had it published in a small trade journal, *The Southern Pharmacist.*

Metchnikoff had published earlier than this by one year.

In 1883, he published in two scientific journals in Vienna, but in 1884, he first published in a medical journal, *Virchow's Archives.* I do not think any publication of the doctrine had been made in this country until after I had read my paper, certainly not to my knowledge, so while I cannot claim to have been the original discoverer of this important fact in medicine, I do claim to have discovered it independently.

Dr. O. W. Roberts: I agree with Dr. Palmer that we do not need bichloride solution in operative wounds, but in the class of cases which he has mentioned—railroad injuries, injuries by machinery, etc., where the injured parts are necessarily in a dirty condition, I always feel safer in the use of bichloride solution, 1 to 5000; but I at the same time take the precaution after using the solution, to thoroughly wash the wound with sterilized water so as to get rid of any of the bichloride that may have been left in the wound.

I believe in these cases very frequently, the mercury that is left in the wound not only produces a local effect but also produces a constitutional—the toxic effect of the drug. I had one or two cases some years ago, where the toxic effects of the drug were very manifest, producing distressing gastric and intestinal symptoms which were very difficult to control; in one case I also had salivation. Since then I have never used bichloride in recent wounds without afterward washing it out thoroughly with hot water. In these cases I very frequently get union of the whole surface of the wound—primary union without suppuration. In addition to washing out the wound with hot water after using bichloride, I use over the wound a piece of rubber tissue for protecting the raw surface from the bichloride used in the dressings—I use bichloride and iodoform gauze.

Dr. W. C. Dugan: I will say that my faith is rather weakening in bichloride; I have seen a number of cases which I am sure were aggravated, and union prevented by its use. I remember a case similar to the one referred to by Dr. Palmer, which I saw the 24th of last December. A boy had his finger caught in a machine of some sort and came to my office with his finger crushed and covered with oil and black grease from the machinery; I simply removed it with scissors, shaped the flap and brought it together, washing with hot water, good soap and brush; it healed under one dressing without any bichloride—without any antiseptic whatever. I recently operated upon a case at the Sts. Mary and Elizabeth Hospital, using bichloride which caused excessive necrosis of the wound without any bacteria—simply chemical necrosis—causing a great deal of disturbance in the union. I can recall a number of cases of the kind. I used to use bichloride solution and felt at times that it did a great deal of good. On the whole I am inclined to think that this solution has had its day.

Dr. W. L. Rodman: This is a subject much to my liking—or better disliking. In truth it is a "theme upon which I will fight until my eyelids will no longer wag." While preparing my thesis on pneumonia fourteen years ago, I read Juergenson's article. I remember that he spoke of Niemeyer as the "Quinine hater." I have been known for many years by those with whom I do most of my surgical work, as a bichloride hater. It has served myself and my patients badly. The greatest objection to it is that it causes in many persons, a dermatitis or mercurial eczema, which is no slight thing, as any one who possesses the idiosyncrasy will testify. After immersing my hands in a solution as weak as 1 to 5000, they begin, in four or five hours, to redden and then swell. The itching is simply intolerable and beyond the power of language to ade-

quately describe. The itching continues for several days, being always worse at night, and when desquamation begins I lose my skin as does a snake.

Now if my own was a solitary experience, I would have little ground to seriously advise the discontinuence of bichloride in surgical work; suffering from it as I have done so many times, my observation has been particularly directed to the effect of the drug upon others skins. I could name scores of surgeons, nurses and patients who have been no less unfortunate than myself. Then again every one admits that any cutting instrument coming in contact with the weakest solution of bichloride, will be ruined thereby. With such objections to its use, it has no legitimate place in surgery unless it can be shown to possess advantages over all other agents. I deny that this can be done. In fresh, surgically clean wounds, it is now admitted by a majority of surgeons, that *all chemical agents* had better be dispensed with. We are running to *asepsis* rather than to *antisepsis*. Chemical germicides are only for use in septic wounds. Who uses bichloride at the present day in the abdomen or other large cavity? Formerly every one did. Gauze was formerly immersed in a bath of 1 to 500. Now we rarely see it stronger than 1 to 2000, and generally 1 to 5000. I speak of these things to show that it has had its day. I have seen an abdomen so raw as to look like a tomato as the result of applying gauze (moist) 1 to 2000. You rarely see moist bichloride gauze now at all, because of its irritating properties. Every attempt has been made to overcome the disagreeable effects of bichloride in surgical work and hitherto without success. I have been fighting it here in Louisville for many years single handed; I have borne the brunt of battle in many of our society discussions, and am glad now to know that in the future I am to have such allies as Dr. Vance and Dr. Dugan—they are good fighters and we say to the opposition, "Let slip the dogs of war."

Dr. Wm. Bailey: I only want to say that I could very appropriately express myself in the language that has immortalized one man: "Where am I at?"

Looking over this whole question there have been some wonderful changes. We doctors have been envying surgeons during the last ten or fifteen years, by virtue of the advancement in the art of rendering inactive the various germs by the various methods, solutions, etc., now it seems that they are about to dispense with one of them. I remember very well when carbolic acid was first introduced as an antiseptic we thought it was a wonderful thing; then after a while corrosive sublimate was introduced, which was claimed to be far superior to anything else as it would destroy the germs. Now it seems that neither of these agents has any power to absolutely destroy the micro-organisms.

In cases such as spoken of by Dr. Palmer, it is a question in my mind whether the oil itself is not antiseptic, and whether recovery would be as prompt without the use of bichloride, so long as this will not kill the germs. For a long time I have felt very well satisfied in going to a case of labor, by having my hands perfectly clean, using an antiseptic solution for bathing, that everything was entirely safe and I could make an examination with a great deal of confidence. Now it appears that the so-called antiseptic solutions are of no benefit—"Where am I at?"—Have you anything that is of benefit?

Dr. C. Skinner: I discarded bichloride solution about a year ago and have been watching the results.

In abdominal work I employed a silk ligature and sutures which had been soaked in a solution of bichloride—making the "ideal suture." The bichloride acting upon the tissues to form the albuminate of mercury which was supposed to be germ proof. This suture I discarded for the silk worm gut and had three consecutive cases of stitch abscesses. The cause I traced to lack of care on the part of nurses in sterilizing instruments and material, and now since I attend to all this work myself I see no pus. It is not safe to intrust this all important work of sterilization to nurses, for they do not as yet realize its importance. I think we can get just as good results from the use of clean boiled water in surgical work, if our instruments and everything else used in the operation are properly sterilized, as by the use of any antiseptic solution yet introduced.

Dr. A. M. Vance: I have not much to say in closing. I am very glad the

subject has been so thoroughly discussed. I do not think cases of the character Dr. Palmer mentions prove anything for bichloride. Of course, the wound should be cleansed of cinders, grease, etc., but I fail to see how corrosive sublimate could possibly be of benefit.

I feel sure that Dr. Roberts will recall a number of cases of amputation that have suppurated without his being able to account for it, except for the fact that he used solution of bichloride of mercury 1:2000, which, undoubtedly, produced necrosis. I think this solution is especially harmful in fresh wounds, as it not only will not absolutely destroy microorganisms, but it prevents healing because of the necrosis it produces.

Regarding Dr. Bailey's remarks, the history of medicine, as well as surgery, is constantly undergoing change. He is probably now using medicines that he did not dream of five years ago, and discarding remedies that he formerly used constantly.

I fully agree with what Dr. Rodman has said, that corrosive sublimate has had its day, and that, in a few years more, it will be regarded in about the same light in surgical practice as carbolic acid is to-day.

The Treatment of Acute Intestinal Obstruction.*

L. Rehn, (*Archiv. für Klin. Chir.* bd. xliii, hft 3. 4,) speaking from personal experience, advises early surgical interference in cases of acute intestinal obstruction, and presents on the whole very good results. He gives a short history of thirteen cases of acute intestinal obstruction with ten recoveries through operative interference, most of which necessitated considerable manipulation.

In some cases the diagnosis regarding location was not clear, while in others he was able to locate it definitely. Most of the cases were the result of strangulation or torsion. One was due to an acute angle produced by mechanical pressure, resulting from suppurating masses; this was at once relieved by simply removing the pus pockets. In another case the occlusion was due to a displacement of the flexura sigmoidea through pressure induced by an abdominal pregnancy.

*Translated for the MEDICAL AND SURGICAL REPORTER by Marie B. Werner, M. D.

As usual the conditions found were rarely alike in two cases. The diagnosis was in most cases easy, eight times fecal vomiting was present. Rehn places great value upon auscultation of the abdomen in order to aid in localizing the peristalsis in cases where this can not be seen.

The author wishes to make a distinct classification between those cases in which obstruction arises outside of the intestinal wall, and those in which the lumen of the bowel is obstructed from the interior. This latter can only be considered secondarily in acute strangulation, since the fate of the tried bowel may be already sealed before any marked symptoms of obstruction of its lumen present themselves, hence strangulation of the bowel, in the author's opinion, can be more certainly diagnosed if the attack is sudden, grave; accompanied by severe pain and followed soon by collapse. Such cases must be treated on a similar plane as strangulated hernia, namely, prompt surgical interference.

The author believes that such strangulations are more dangerous to the vitality of the bowel than cases of strangulated hernia. The complication with suppurating processes, such as typhlitis, require that the attention be directed to a careful removal of all products of suppuration. In cases of chronic increasing obstruction the author gives no precise regulations regarding diagnosis or treatment.

If operation becomes necessary he prefers enterostomie, and only in those cases where a definite knowledge of the location and nature of the obstruction is present. An exploratory incision may often be necessary to establish this.

Black Eye.

There is nothing to compare with a tincture or a strong infusion of capsicum annum, mixed with an equal bulk of mucilage or gum arabic, and with the addition of a few drops of glycerine. This should be painted all over the bruised surface with a camel's-hair pencil, and allowed to dry on, a second or third coating being applied as soon as the first is dry. If done as soon as the injury is inflicted, the treatment will invariably prevent the blackening of the bruised tissue. The same remedy has no equal in rheumatic, sore or stiff neck.—*Medical Times.*

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SATURDAY, APRIL 8TH, 1893.

EDITORIAL.

PROFESSIONAL COURTESY.

Anent professional ethics, whether the code shall or shall not be revised, THE REPORTER calls attention to a fundamental element that appears to have escaped notice. The factor is of such importance that if its faults remain uncorrected every attempt to revise or reform a code of rules will prove futile; while if the faults are eliminated there will be no necessity for the existence of a code. This important factor is the *personal equation*, and the more important defects are summed up in the term *selfishness*. Correction of the defects of this fundamental factor unravels the entire tangle of the "Code of Ethics."

The solution is so simple and practicable that in all probability it will receive but scant consideration. Its simplicity may prove an objection in some quarters for it would bear equally and alike upon every individual in the profession, and might subject some enthusiasts to the disagreeable suspicion that their loud talking was prompted by some motive other than anxiety for the public weal. Its practicability might not inspire support from all quarters, but the profession at large would regard it with satisfaction, in that each individual would be charged with the oversight of but one man, would be relieved of the necessity of searching out and contemplating the shortcomings of his fellows and would be enabled to devote the considerable time thus economized to scouring possible rust specks from his own escutcheon.

The key to the whole problem—and there is but one key—is the good old-fashioned Golden Rule.

This rule is as applicable to professional intercourse in medicine as it is to any other relation in life.

It would be easily applied and readily observed were medicine practiced in a more disinterested spirit. Were the contribution to scientific knowledge the ulterior motive and the relief of suffering the immediate object of each practitioner, there would be no room for envy, no mo-

tive for jealousy, no opportunity for backbiting and no excuse for disparagement. Science requires the keenest scrutiny, the most severe tests and the fullest and freest discussion of every offered effort at advancement, but it also requires the total elimination of the personal equation. Unfortunately few discussions of medical innovations are entirely scientific in this latter respect.

A disciple once told the Master that an unauthorized person, over in a neighboring locality, was casting out devils in his name, and that he had been forbidden to continue the practice. The Great Physician responded—"Forbid him not, for he that is not against us is for us." He recognized only the fact that one engaged in the god-like office of ministering to the afflicted was neither more or less than a brother.

But in modern times devils must be cast out in the good old orthodox way (orthodoxy is *our* doxy, all else is heterodoxy), or we may not recognize the man who does it. Having learned that the stones we have been casting at our heterodox brethren have served only to build higher the pedestal on which they pose before the world, we begin to look around, and if we notice any one of our own sacred caste doing things in a brilliant or original manner, "we rise up and smite him with misrepresentation and calumny." Yea, verily we call him a prevaricator. We prove not only that he does not do what he claims, but we bring witnesses who testify that he does it in a very unorthodox way. That his procedeures are not justifiable, we have documentary evidence in the shape of an unbroken line of authorities beginning before the birth of authentic history and continuing even to this day. If this gentle expostulation does not lead our brother from the errors of his way, we formulate an ultimatum that certain conditions are incurable; that, for reasons we proceed to name, certain methods are "brutal and inhuman and not excusable on any reasonable ground." This ultimatum we tie on the tail of our sacred bull, Infallibility, and turn it loose to edify the public.

When cowardly insinuations that "a prominent professional man" is using just such methods, and for the very reasons that we have announced to be false and dangerous, reach our surprised ears, we shake the head and whisper—"Is it possible!" Well I am not surprised after all. He is afflicted with a swelled head. In fact I have long regarded him as a very dangerous man. Tomtit says he stole some cases from Blaggard. He says he is willing to swear to it, for Mendax told him that Jacquass heard it discussed at Allgab's table. Now don't you think some measures should be taken to end this disgraceful state of affairs? If we let this thing go unchecked there is no telling who will be exposed next. Confound the fellow! He knows too much, and we must muzzle him. Well, so long! If there is anything I despise it is a mischief-maker. Scavenge is on his rounds now and when he sees you doubtless he will give information of personal interest to you."

If our erstwhile companion remains unconvinced we hail him before the Council. This conclave of grave and reverend seigneurs we persuade to sit on him, and, in order to make their influence ponderable, we call to their assistance some modern Samson with a reputation of slaying thousands with the jaw-bone of an ass—even his own.

If all these things move not the offender we resort again to painstaking and industrious lying.

This hypothetical process is duplicated in every community that contains a live, progressive and successful man. What is true of reformers in all other lines obtains in the medical profession likewise, and is due largely to the variable

personal equation. This unfortunate condition is not true, perhaps, of the majority of individual members, but it does mark the profession collectively. This may seem paradoxical, but it is true, nevertheless, as history abundantly shows. For instances, concealing the skeletons in our own closets, we mention but one or two remote cases.

When McDowell published an account of his first abdominal section, the editor of a leading English journal denounced him as a liar—then apologized for the insult.

No member of the English profession of to-day likes to hear the name of Baker-Brown. The story of the jealousy and meanness that drove Baker-Brown out of the London Obstetrical Society, ruined him financially and eventually landed him in a mad house, is too recent to moderate the shame of the profession.

But similar efforts to bury under a load of contumely the men whose genius builds the monuments of medical progress in the closing decade of the Nineteenth century, are being made to-day, both at home and abroad.

In its ultimate analysis the inspiration is the defect of the personal equation—selfishness. It is that which compels the existence of a code; and so long as it remains sovereign in influence no code can modify it. When eliminated no code will be necessary.

THE MEDICAL EXAMINER'S BILL FOR PENNSYLVANIA.

The bill establishing a State Board of Medical Examiners has passed the House. The present bill may not be perfect, but it is a safe one upon which to base future legislation.

The bill provides for the appointment by the Governor of three boards for the examination of all applicants for license to practice medicine or surgery. Each board to consist of seven members whose term of office shall be three years. One will represent the Medical Society of Pennsylvania, one the Homœopathic Medical Society of Pennsylvania, and the third the Eclectic Medical Society of Pennsylvania. The appointments are to be made from the full lists of members of these societies.

The duty of these boards ends with the examination of applicants and the recommendation to the Medical Council of Pennsylvania, which is established by the same bill.

The Council will consist of the Lieutenant-Governor, the Attorney General, the Secretary of Internal Affairs, the Superintendent of Public Instruction, the President of the State Board of Health and the Presidents of the three State Boards of Medical Examiners. It will be the duty of the Council to supervise the examinations conducted by the examining boards, and to issue licenses to those who have successfully passed the requisite examination or have been recommended for license by one of the Boards.

C. Chlorodyne.

This is the name given at the Walajabad Mission Dispensary for a chlorodyne much used there in cholera cases (*Calcutta Medical Reporter.*) The formula is:

℞

Spt. menthæ. pip.	ʒij.
" camph.	ʒij.
" chloroform.	ʒij.
Tinct. capsici.	ʒij.
" zingib.	ʒij.
" catechu.	ʒvj.
" digitalis.	ʒj.
Acid hydrocyanic. dil	ʒij.
Glycerini.	ʒiij.
Spt. vini. rect.	ij.

M. mxx. in ʒj. of water every fifteen minutes, until vomiting and purging stop.

When the cases come, Dr. W. Walker states that treatment is begun at once with 20 drops of the chlorodyne, in a teaspoonful of water, and if necessary the same amount is given every fifteen minutes; but it is seldom found that more than one or two doses are required. At the same time the usual specific treatment is carried out.

TRANSLATIONS.

RUPTURE OF THE BILIARY PASSAGES IN CONTUSIONS OF THE ABDOMEN.†

In *Le Bull. Med.*, Feb. 5, 1893, Routier, of Paris, comments upon the progress made of late years in the surgery of the abdomen; that through this advance we are now able to treat successfully lesions that otherwise would only be discovered on the autopsy table, such as rupture of the intestines. He reports a case of traumatic lesion of the liver occurring in a little boy of thirteen years, who was seen in his hospital service at Cochin, suffering with all the signs of an acute peritonitis—distension of the abdomen, extreme pain, shriveled features, pulse small and thready, tongue dry, repeated vomiting, rather bilious. These symptoms had suddenly developed after a kick in the right hypochondrium which had provoked an immediate syncope. The bowels had been unmoved since the traumatism, the urine was scanty and red; fortunately the child passed some flatus. This fact itself assured the integrity of the intestines and rendered the course to be pursued very simple. Two large bladders full of ice were applied to the stomach; the diet was absolute, and a small injection of morphine was made. The amelioration was rapid, and so decidedly so that on the sixth day, in spite of advice to the contrary, the child was removed to its home. This was a bad move for, two weeks later, his mother brought him back in a pitiable condition. Now the child was weak and emaciated, with alternating diarrhœa and constipation; his peritonitis was rather sub-acute although with fever, but the local signs especially had much changed. When on his first sojourn in the hospital his abdomen would scarcely tolerate touching, so great was his pain, but now palpation, although still painful, was nevertheless possible. It was also easy to recognize fluctuations throughout the whole extent of the right side of the abdomen. The tympany appeared general at the first examination, but now while the whole left side remained tympanitic, the entire right side of the belly was flat. The mother said that when in his seventh year he had been attacked with symptoms analogous to those that had followed the kick, resulting from a fall upon the stomach, but not so grave, consisting mainly in alternating periods of diarrhœa and constipation. This history threw Routier off the track and caused him to modify his diagnosis. He thought now that the recent traumatism had lighted up a dormant tubercular peritonitis, and with the idea of treating a peritonitis of this nature he proposed to the mother the performance of laparotomy. An incision was made in the median line below the umbilicus, and he immediately came down upon an oval mass of agglutinated intestines, adherent to the anterior walls, so that considerable care was required to prevent tearing them. As soon as he had opened the peritoneum there escaped about a liter and a half of a greenish-brown liquid resembling bile in every particular. He again modified his diagnosis to that of rupture of the biliary passages, especially as the false membranes did not have any of the tuberculous appearances and as there were no traces of granulations upon the intestines. These membranes were very thick in the middle line and especially towards the liver, the inferior surface of which they completely masked. There was thus formed a sort of antero-posterior wall by the mesentery, the agglutinated coils of intestines and the omentum which acted as a barrier to the liquid. However, as this wall approached the pelvis it became less complete, the false membranes disappearing and the intestinal coils preserving their normal lustre, although tinged green by the bile. It was thus that the fluid was able to penetrate into the pelvis and to rise again, although in small quantity, on the left side of the mesentery. The thickened masses of exudate which concealed the lower surface of the liver, and which were believed to have a curative action, were not removed; the fluid was allowed to escape and the abdomen was closed. The after course was very simple.

†Translated for THE MEDICAL AND SURGICAL REPORTER, by W. A. N. Dorland, M. D.

Eight days after the operation there was no reproduction of the effusion, and some days later the child went out cured. There was no doubt as to the nature of the lesion; the traumatism had caused a rupture of the biliary passages and the effusion of the bile had produced the partial peritonitis which the operation had caused.

These cases are quite rare, but curious to note they are all the same, so that the observations that Routier has been able to collect appear all based the one upon the other. From these observations and from the results of experimental pathology he has been able to trace a sort of schema of this variety of abdominal traumatism. In nearly every case there is a history of abdominal contusion from a force whose application was made upon a small surface —in the above case, the end of a boot— the tip of a carriage pole, as in the case of Arbuthnot Lane; the end of the beam of a fire engine, as in Drysdale's case, or the end of a wagon shaft, as in the case cited by Uhde. However, the cause is very often obscure. In the observations of Fryer, of Thompson, and of Landeser there is simply made mention of a violent shock. To explain the rupture of the bladder or bile passages, Routier willingly accepts the following hypothesis: The contusing body acting by a sharp extremity and striking the patient from below upwards in the subhepatic region takes the abdominal wall by surprise, immediately effacing the lumen of the ductus choledochus or of the gall-bladder, by pressing against the lower surface of the liver retained in the concavity of the diaphragm; the bile imprisoned in the bladder or canals is not able to escape; the pressure increases and the liquid causes the walls to give way.

He gives as the result of his researches and practical experiences the following conclusion: When a surgeon is brought face to face with an abdominal contusion, especially in the hepatic region, and there is reason to believe that there does not exist an intestinal rupture, it is better to bear in mind the possibility of rupture of the bile passages. The patient then should be placed in a state of absolute repose with restricted diet, ice should be applied over the abdomen, opium administered internally, and palpation observed to gauge the moment when the general symptoms become quiet. Then all that must be treated is the abdominal effusion, and experience has proven that nothing is comparable to a simple laparotomy. The result is always satisfactory.

A Case of Incipient Ischiatic Hernia.*

The patient, a woman, aged 41, had been suffering for nine days with constipation and fecal vomiting; was admitted into the surgical department of v. Hacker.

A fracture of the left thigh was at first regarded as the cause of the symptoms of strangulation present. Herniotomy, however, revealed no such strangulation. Laparotomy was resorted to on the same day by v. Hacker, who found that near the end of the ileum, about two finger breadths (spannen) of the bowel had passed through a recess of the parietal peritoneum and become strangulated. This recess was found in the left portion of the small pelvis in the region of the incisura ischiatica.

After releasing the strangulated portion of the bowel, and closing the abdomen, the symptoms of incarceration were at once relieved. The patient, however, died on the sixth day of lobular pneumonia of the right lung.

The author was unable to find any cases in literature quite analogous to his, since the anatomical descriptions of such hernia usually place the sac in another position to the obturator and hypogastric arteries than in his case.

Langer's explanation, however, is that all hernia of this nature, which passed through the opening between the incisura ischiatica major and the upper margins of the pyriform muscle, originates, more or less, from internal hernia, and for that reason regards his case as one in its early stages. Until the present time eleven cases have been published under this head, the author's being the first in which the condition was relieved by operative means.—(A. Langer, *Centralb. für Chir.*, No. 9–'93.)

Irritable Bladder with Acid Urine.

℞ Spts. ammon. arom. }
Æther nit. } .....aa dr. ij.
Tr. hyoscyami }
Aq. camph., qs.....ad. oz. vi.

M. Sig. One oz. three times a day.

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*Translated for The Medical and Surgical Reporter by Marie B. Werner, M. D.

CURRENT LITERATURE REVIEWED.

THE AMERICAN JOURNAL OF THE MEDICAL SCIENCES

For April contains

A Contribution to Cerebral Surgery,

By Drs. Charles McBurney and M. Allen Starr. The questions of the diagnosis, localization and operation for the removal of tumors of the brain are discussed and three cases of brain tumor reported in which operation was performed.

CASE I. Sarcoma of the left frontal lobe. Successful removal, subsequent death. The case is reported in full with cuts showing the site and appearance of the tumor.

CASE II. Fibro-sarcoma of the cerebellum and pons varolii; staggering away from the side of the tumor; operation; death. The autopsy showed that it would have been impossible to have removed the tumor owing to its situation.

CASE III. Glioma of the cerebellum; characteristic staggering; operation; death. The tumor was not removed, as it occupied the vermiform lobe of the cerebellum and was not discovered during life.

Operations on the brain more frequently than in any other part of the body, are exploratory, and, in spite of the constantly increasing knowledge of the subject, the operator will probably always be in doubt as to the possibility of removal of the tumor until it is reached. While exploratory operations in other parts of the body are often simple and devoid of risk, it is not so in the brain, where unexpected difficulties, even serious accidents are liable to occur at any stage of the operation. The chief danger is from hemorrhage, which begins from the moment the scalp is cut and varies greatly with different cases. The incisions in the scalp should be free and horse shoe-shaped, the author's preferring the method suggested by Wagner, which consists in cutting through the skull with a chisel in the line of the scalp incision, the scalp flap not having been turned back. This bone flap with scalp flap still attached is then pried up and turned back, thus exposing as large an area of dura mater as the original incision outlined. To open the dura the authors prefer to cut directly down upon it with the knife at a point an eighth or a quarter of an inch away from the bony margin. When an opening is made, small blunt scissors may be introduced and the whole flap of dura, similar in shape to the bone flap, turned back. Picking up the dura mater with a tenaculum is more likely to be accompanied by a wound of a vessel in the pia mater. As a rule if removal of a tumor is begun it must be completed. Hemorrhage from a wounded vessel in the pia mater is best controlled by the cautery if the vessel is small; larger ones may be compressed by a sponge in the hands of an assistant and the cautery or ligature applied later if necessary. A wound in a sinus had best be packed with gauze, if large. If small enough it may be closed by one or two pairs of pressure forceps which may be left in position for two or three days. It is is useless to try to ligature or suture a wounded sinus. Free hemorrhage from the cavity left after removal of the tumor should be met with gauze packing. In operating on tumors of the cerebellum the danger of wounding the sinuses is too great to allow of the application of the method of entering the skull mentioned above. Here it is better to sacrifice the bone and remove a button with the trephine, enlarging the opening if necessary.

The diagnosis of cerebellar disease is asye; headache, vomiting, vertigo, blindness and staggering being the symptoms almost uniformly found. It is yet almost impossible to locate accurately the disease within the cerebellum. The symptoms of greatest importance in the location of cerebellar disease appear to be those arising from the involvement of the cranial nerves upon the base. The disease commonly lies upon the side upon which those nerves are affected.

The two cases reported bring the number of operations for cerebellar disease up to thirteen. In six cases the tumor was not found at the operation and the patient died. In one case the tumor was not found but the patient was alive at the time of the report. In two cases the tumor was removed, but the patient died. In two cases it was found but could not be removed and the patient died. In one case it was found, not removed, but the patient lived. In but one case was the tumor successfully removed. The percentage of deaths after cerebellar operations thus far has been 77 per cent., while that after cerebral operations has been 51 per cent. If the results of the cerebral operations be combined with those of the cerebellar, we find that the total number of patients operated on for intra-cranial tumors has been eighty-seven, and that of these, 40, or 46 per cent., have proved successful, the patients recovering.

This issue contains two papers on

Symphysiotomy.

Dr. Henry J. Garrigues continues the report of a successful case begun in the March number. His conclusions are as follows: The distance between the ends of the bones after symphysiotomy can readily be increased to two and three-fourths inches without injury to the sacro-iliac joints. If the separation is carried to three and one-eighth to four inches the joints, one or both, crack and open. The indications and limits of the operations are discussed and for flat pelves, found to lie between two and three-fourths and three and one-half inches. In the generally contracted pelvis the author places the upper limit at four inches, C. V. In performing the operation the operator sits on a chair between the legs of the patient, which may hang down over the end of the table or

lie outstretched during the first incision, but during the incision of the symphysis should be held bent in hip and knee-joint, moderately separated with the feet high. The transverse incision into the recti muscles advocated by Morisani, the author thinks is not necessary and weakens the abdominal wall. After cutting down on the symphysis, the finger is introduced behind the bone and Galbiati's falcetta introduced, the cut being made from behind forwards and from below upwards. In this way the bladder is avoided. The whole symphysis, inclusive of the subpubic ligament, should be cut. The urethra is protected against injury by being held over to the right side by means of a long metal catheter. The bladder and vagina are guarded by the finger held behind the symphysis or by passing a director. Assistants should press moderately on the trochanters, and in this way avoid too great strain on the articulations. The soft parts should be held apart during extraction. As to the furthering of labor after the symphysis has been severed, the author thinks the woman should be delivered at once and not left to nature as Morisani advises. The common rules of delivery hold good—forceps for the engaged head, turning for a head movable above the brim. If the placenta does not come away within fifteen minutes after delivery of the child it is better to loosen it artificially before closing the wound. After delivery of the placenta the bones are brought together by pressing on the trochanters,and deep sutures introduced through the skin, adipose and fibrous tissue down to the bone. Great care should be taken to see that the bladder and vagina do not get in between the ends of the bones. Broad bands of rubber adhesive plaster surround the pelvis and the patient should lie with outstretched legs as this position tends to bring the end of the bones together. The author thinks it safe to let the patient get up at the end of three weeks. In relation to other operations, the operation of craniotomy on the living child, which has been so universally condemned, will vanish from the list. Induction of premature labor will be much restricted. The improved Cæsarean section holds its own when the conjugate is below $2\frac{3}{4}$ inches. The operation of symphysiotomy should be performed as soon as labor is sufficiently advanced, as delay only adds to the dangers. The operation should only be undertaken by the skilled operator.

[The whole paper is a clear dispassionate statement of the entire subject of symphysiotomy and is a valuable contribution to our knowledge of the operation.—Ed.]

The other paper on symphysiotomy is by Dr. William T. Lusk and is the report of a case in which the operation was performed on a primi para who had been in labor for twenty-two hours. There was a brow presentation and version and extraction by the forceps had been tried by the attending physician without result. The child lived seventeen hours; the mother died on the afternoon of the day following the operation. The reporter does not think the operation responsible for the fatal result.

Dr. George M. Edebohls concludes his paper on "Movable Kidney." The author describes the operation of nephrorrhaphy as he is accustomed to perform it, and states that the mortality is practically *nil.* For buried sutures to fasten the kidney to muscle and aponeurosis, he uses silkworm gut exclusively. The paper included the detailed report of the twelve cases in which he has performed the operation.

Dr. D. D. Stewart contributes a paper on "The Prevention and Treatment of Cholera by the Naphthols." The paper includes the bacteriological report by Dr. George M. Sternberg on the subject.

Dr. L. Duncan Bulkley discusses the "Internal Treatment of Lupus Erythematosus with Phosphorus" giving the formula of the solution used by him. The paper included the report of cases cured or much benefited by the treatment.

Dr. Leo Newmark presents "A Contribution to the Study of the Family Form of Spastic Paraplegia," reporting the cases in two families in which the disease occurred. The paper is illustrated with the photographs of three of the patients.

THE VIRGINIA MEDICAL MONTHLY

for March contains an article by Dr. William A. Thom, Jr., on "The Quarantine of the Future," in which the glaring defects of quarantine as now constituted are reviewed and suggestions made for the betterment of the service. He suggests the appointment of a commission of five, by the Federal government, who shall have supervision of quarantine matters and be assisted by a corps of inspectors. The plan also includes the establishment of disinfecting plants at various points and regular reports from consuls as to the sanitary condition of the country in which they are stationed.

Dr. R. L. Payne presents "Some Practical Observations on Treatment of Typhoid Fever." In speaking of hemorrhage from the bowel and the generally accepted idea that it is a most unfavorable symptom, he says he has "seen many a case in which the effect of the hemorrhage seemed to be beneficial when it was arrested before dangerous collapse came on." Quinine he thinks a bad antipyretic and as a tonic it has not answered as well in his hands as serpentaria. Quinine he thinks increases the nervous symptoms even if it does not cause them. Antipyrin, antifebrin and others of the coal tar products have answered well in some instances, but in general are uncertain and the prostration which sometimes follows their use more than counterbalances the benefit. As an antipyretic there is nothing, in his opinion, like cold water, either in the form of the cold pack or frequent sponging over the whole body.

Dr. Simon Baruch contributes a paper on "Practical Data of the application of Water in some Intractable Diseases," reporting a number of cases cured by a water treatment. He sums up his paper as follows: "We pos-

sess in this method a valuable auxiliary to methodical treatment of many, though not all, acute and chronic maladies. In many chronic diseases it has proved so successful after failure of medicinal remedies, that no case should be yielded up as hopeless until hydrotherapy, in some form, has been tried. Domestic treatment will suffice in most cases, but if these fail, a methodical treatment under an expert hydrotherapeutist may be of advantage to the patient."

Dr. O. M. Smith reports a case of "Tracheotomy at Nineteen Months—recovery." The child had been given half of a chinquapin by her brother which lodged in the trachea. It was impossible to dislodge the fragment and tracheotomy was proposed but rejected by the parents for three days till the child developed a traumatic pneumonia. At the operation the fragment was driven out through the incision and five days later the husk was also discharged. The child made a perfect recovery.

Dr. John Walker reports a "Case of Gunshot Wound through the Knee-joint, with recovery without limp." The ball entered the knee at the tibia-femoral articulation on the inner side of the joint, passing through the joint and lodged under the skin on the outer side of the limb. The ball was removed, the wound washed out with 1 to 2000 bichloride of mercury solution, dusted with aristol and put on a long splint, extending from the hip to the ankle, thus securing absolute rest. At the end of the sixth week the patient had perfect use of the knee with normal motion.

Dr. A. S. Priddy reports a case of "Abdominal dropsy mistaken and operated on for an Ovarian Cyst."

Dr. Frank T. Chamberlin reports an abscess of the epiglottis in which recurrence took place after the evacuation of the abscess cavity. The report is illustrated with cuts of the appearance of the abscess.

Dr. T. N. McLaughlin presents some "Notes on the Therapeutical Action of Thiol in the Treatment of Skin Diseases." He uses the drug extensively in the various forms of eczema and reports good results from it. In furuncles and in one case of carbuncle it proved highly beneficial. It can be administered internally in doses of from three centigrammes to one gram, three times a day. Deleterious effects have not been observed. It possesses the following advantages over ichthyol: it is odorless and does not stain the clothing. It can readily be removed from the surface. All the desirable therapeutic properties possessed by ichthyol may be claimed for thiol.

The other papers in this month's magazine are: "Hysterectomy with report of a difficult case successfully treated," by Chas. G. Cannaday.

"Certain animal extracts" by Dr. William A. Hammond, which has already been noticed in THE MEDICAL AND SURGICAL REPORTER for February 11th, page 235. "Case of Early Diagnosis of Tubal Pregnancy" by Dr. Hugh M. Taylor which has been reviewed in the THE MEDICAL AND SURGICAL REPORTER for April 1st, page 513.

JOURNAL OF CUTANEOUS AND GENITO-URINARY DISEASES.

The March number contains an article by Dr. Hyde on "The Cutaneous Cicatrices of Syphilis" of which fuller mention is made elsewhere in this issue.

Dr. Morison reports "An Unusual Case of Syphilis" which is merely a record of a case of simple syphilis over-treated in the beginning, which was rendered obscure by a peculiar susceptibility of the system to both potash and mercury.

Reports of "A Case of Acute Circumscribed Œdema of the Skin" by Dr. Russell, and "A Case of Congenital Syphilis" by Dr. Hessler complete the list of original communications.

Under "Society Transactions" are reported the proceedings of the New York Dermatological Society, and Section of Genito-Urinary Surgery of the New York Academy of Medicine.

THE NEW ZEALAND MEDICAL JOURNAL.

The quarterly issue for January offers fourteen papers.

Dr. Cleghorn reports the "Treatment used in five cases of Chronic Suppuration, without drainage by the Barker Method," which consists in making small incisions, the thorough removal of the pyogenic membrane by scraping with the finger or special instruments, washing out with large quantities of very hot water, filling the cavity with iodoform emulsion which is squeezed out and bringing the edges of the incisions together with silk sutures without any provision being made for drainage. Dr. Cleghorn also reports "Two Cases of Cerebral Tumor, Localizing Symptoms, Operation." The object in reporting these cases is to obtain an expression of opinion as to the advisability of further operative procedure in case symptoms return, as it seems only too likely they will do. The doctor contributes in addition to these two papers, one as a report of "Two Cases of Acute Purulent Synovitis (knee and ankle) treated by incisions and washing out well with Peroxide of Hydrogen. No drainage. Recovery, with perfect joints."

"Radical Cure in Strangulated Hernia," and "Hydronephrosis of Kidney" by Dr. Gillon, together with a "Report of the Examination of Fallopian Tubes in Three Cases of Tubal Gestation" by Dr. Mackenzie, complete the more important papers.

THE THERAPEUTIC GAZETTE

for March contains five original papers; two are clinical lectures, and three leading articles or editorials. We select from these as the most important

Sympathetic Irritation and Sympathetic Serious Iritis with Cases.

Dr. de Schweinitz in speaking of the affections in which one eye is implicated as the result of disease or injury to the other—sympathetic irritation and sympathetic ophthalmitis—repeats some rules which cover the ground as well as it is possible to do. The

rules are quoted from those which are given by Mr. Swanzy.

"You should perform enucleation, or one of its substitutes, on,—

(1) An eye with a wound which involves the ciliary region to such an extent that sight is immediately destroyed, or that its ultimate destruction by the process of inflammation is practically certain.

(2) An eye which has been wounded in the dangerous region, and in which severe inflammation of the iris or ciliary body has already begun, even if sight is not destroyed.

(3) An eye which contains a foreign body which judicious efforts have failed to extract, and when much iritis is present, even if sight is not destroyed.

These three rules, you will observe, apply to preventive enucleation,—that is to say, the operation is performed in order to check sympathetic disease.

Now let me quote you two which should be your guide, provided the sympathetic disease has already begun.

1. You should perform enucleation, or one of its substitutes, on an eye whose sight has been destroyed, even though sympathetic inflammation has begun in the sympathizing eye, because by this means you remove a source of irritation and hope to render the treatment of the sound eye more effectual.

2. You should *not* perform enucleation, or one of its substitutes, on an eye which has been injured, but which retains some vision, when sympathetic inflammation has begun in the sympathizing eye, because in the end it may prove to be the more useful organ.

Under the last-named circumstances you must employ the medicinal treatment suited to the excitor, as well as that needed by the sympathizer. Generally this treatment consists in the frequent instillation of atropine, local blood-letting, and, if the patient is sufficiently robust, the use of mercury in some form, preferably protiodide by the mouth or inunctions, to the point of tolerance, but not to that of salivation, tonic doses of quinine, and concentrated, nourishing food. The light should be excluded, if necessary with a bandage, but there is no objection to the patient having proper exercise, which usually may be given in the room to which he is almost of necessity confined. Should this not be practicable, he may be taken out with eyes properly protected with bandages."

The Treatment of Gonorrhœa.

Dr. Christian's paper is the result of careful observations made at the genito-urinary clinic of the University Hospital. He offers the following summary of two methods of treatment carried out.

Number of cases of acute gonorrhœa treated by injections at a comparatively early period of the disease, 150; uncomplicated with posterior urethritis or epididymitis, 85; developing posterior urethritis, 52; developing epididymitis, 13.

Acute gonorrhœa treated without injections till the subsidiary stage was well developed, 150; uncomplicated with posterior urethritis or epididymitis, 134; developing posterior urethritis, 12; developing epididymitis, 4.

After a comparison of the results obtained by these two methods of treatment, it would seem that there is but one conclusion to be drawn,—namely, that the use of injections, prior to the subsiding stage of acute gonorrhœa, acts, in quite a large proportion of the cases, as an exciting cause in the production of posterior urethritis and epididymitis; and on this account is not to be considered as the best treatment of the disease.

All patients at the venereal dispensary of the University Hospital are now put upon the internal use of a capsule containing five (5) drops of oil of sandalwood and five drops of oil of copaiba, with one drop of oil of cinnamon. From four to eight of these are taken daily for the first three weeks.

When the "morning drop" persists, an injection of sulphocarbolate of zinc and hydrastis is used.

It is not claimed for this plan of treatment that it in any way cuts short the duration of the disease, but only that it aids in preventing the frequent occurrence of posterior urethritis and epididymitis, the two most troublesome complications of gonorrhœa."

THE OPHTHALMIC REVIEW.

To the February number Dr. Ernest F. Maddox of Edinburgh contributes a paper on

The Prescribing of Prisms.

He passes in review the various methods of testing the latent conditions of equilibrium for near and distant vision by the "finger," "rod," and "card" tests, and the test of the "relative range of convergence," by which is meant the extent to which convergence can be artificially increased or relaxed (by adducting prisms) while accommodation remains the same for an object at some definite distance. For the "rod" test Dr. Maddox states that a series of small glass rods about an inch long should be used, "arranged parallel to each other, and in close contact. Any one can make this for himself by breaking up a long glass rod of about one-eighth of an inch in diameter into short pieces of equal length, laying them side by side on a hard surface, to get them perfectly level, and then fixing their ends with sealing wax. The advantage of this form is the ease with which it is held opposite the patient's pupil, for one of the rods must be in front of it. Dr. Maddox refers to the remarkable persistency of hyperphoria. He writes: "In a doctor of my acquaintance I noted at two separate times, so far apart as two years, a persistent hyperphoria of exactly $1\frac{1}{2}°$. The headache from which he has suffered for many years is very likely connected with it, but I have not yet prevailed on him to try prisms."

An abstract of a paper by Dr. E. Emmert (Bern) on "Keratits Dendritica and Herpes Cornea Febrilis" is to a great extent of a controversial character.

PERISCOPE.

MEDICINE

The Nasal Douche.

Dr. L. A. Dessar, in *Inter. Jour. Surg.*, says: The following rules should be observed in the use of all nasal douches:

1. The handkerchief should not be used for at least ten minutes after douching, inasmuch as in blowing the nose, any fluid remaining in the nasal passages may by a Valsalva action be forced into the Eustachian tube.

2. After douching it is advisable for the patient to remain indoors, so as to avoid exposure to the cold air.

3. During the proceeding the patient should not be disturbed or excited, as this may give rise to an involuntary attack of sneezing, coughing, or swallowing, and thus render it possible for fluids to enter the middle ear.

4. Before beginning the douching a careful examination should be made to see whether both nostrils are free. If one of them is found to be obstructed the douche should be used on the affected side.

5. Plain water should never be employed for douching, as it loosens the nasal epithelium. The addition of a small amount of sodium chloride prevents this action.

6. Concentrated solutions should never be used as a douche.

7. It is not advisable to douche the nose more than three times daily. As a rule, its application morning and evening is sufficient.

8. The quantity of fluid introduced should not exceed ten ounces, the average amount varying from five to ten ounces; *i. e.*, from one to two douche cupfuls for each nostril.

9. The fluid should always be luke-warm.—*Med. Brief.*

Symes (W. L.) On Hiccough.

The writer regarding this as a reflex act believes that the sympathetic connections of the Semilunar ganglion convey the centrifugal impressions rather than the phrenic nerve. His reasons are as follows:

The diaphragm appears to contract *before* the laryngeal muscles, pointing to a closer and more direct communication with the gastric portion of the vagus than even the recurrent laryngeal.

2. The course of the phrenic nerve is healthy, and its respiratory function perfect.

3. The patient has no control over the spasm, while the phrenic is always subservient to one's will.

4. Remedies applied to the origin or course of the phrenic, ice-bags, compres spine, such as blisters, or to the cervical sion, etc., etc., have no effect; while those directed to the diaphragm, stomach, and solar plexus, are generally curative.

5. The connections between the pneumogastric and phrenic by means of the 3d, 4th, or 5th cervical nerves, are remote, and if this were the route taken, the impression must travel more than double as fast on the phrenic than it does on the recurrent nerve, since it reaches the diaphragm before the larynx—conditions which are unphysiological.

6. The experiences of Romberg and Bright, which show that direct irritation of the phrenic will not produce hiccough.

7. The existence of a perfect reflex-loop between the stomach and diaphragm, which more directly answers the purpose, separate from the function of respiration and beyond control of the patient.

8. It being influenced by the acts of deglutition or vomiting to a greater degree than by any respiratory efforts.—*Dublin Jour. Med. Sc.*

A Treatment for Round Worms.

Dr. P. Nicholson (*La Semaine Medicale*), commends the following:

1. Give santonine every day for a week only, for fear of poisoning the child.

2. Every evening on retiring, introduce into the rectum a suppository of the following composition:

℞ Ext. quassia.....6-18 cgms. (grs. j-ij¾)
Cocoa butter.....q. s.
Make ten such suppositories.

3. Apply morning and evening a little salve containing a small per cent. of colomel or the nitrate of mercury together with some extract of quassia.

4. Give from time to time the following rectal injection:

℞ Menthol.....6 cgms. (gr. j.)
Olive oil.....30 gms. (℥j)
Sufficient for one injection.

5. Cut the child's finger nails short and now and then plunge into an infusion of quassia to prevent auto-infection from scratching his anus and swallowing the ova. Finally, combat the constipation with calomel.

ARMY AND NAVY.

U. S. ARMY, FROM MARCH 26, 1893, TO APRIL 1, 1893.

Leave of absence for sixteen days, to take effect on or about April 1st, 1893, is granted First Lieutenant George D. De Shon, Assistant Surgeon U. S. Army, Fort D. A. Russell, Wyoming.

Leave of absence for two (2) months on Surgeon's certificate of disability with permission to leave the Department of the Platte, is granted Captain William G. Spencer, Assistant Surgeon U. S. Army.

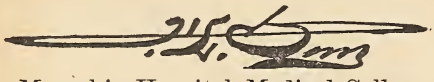
Leave of absence for one month with permission to apply for an extension of one month is granted Lieut. Colonel Charles C. Byrne, Deputy Surgeon General, U. S. Army Medical Director, Hdqrs. Dept. Columbia.

NEUROSINE is the Most Powerful Neurotic Attainable!

ALL Forms of Neuralgia is abated by the use of NEUROSINE. Relieves Completely Restlessness in Fevers, Producing Natural Sleep WITH NO DETRIMENTAL AFTER-EFFECTS.

Memphis, Tenn., Jan. 7, 1891.

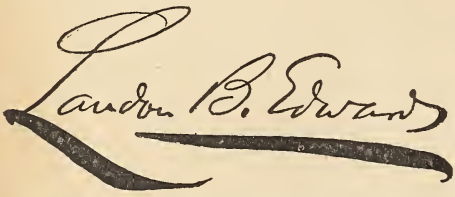
I have found entire satisfaction from the use of your Neurosine in cases of Neuralgia.



Dean Memphis Hospital Medical College.

Richmond, Va., Sept, 29, 1891.

I prescribe Neurosine in the class of cases for which it is indicated, daily, and with satisfactory results. It relieves completely restlessness in fevers.



Editor "Virginia Medical Monthly."

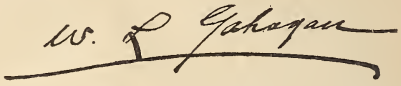
Memphis, Tenn., Feb. 6, 1892.

I take the opportunity to express my gratification at the happy results obtained from the use of Neurosine. It is certainly the best neuralgic remedy I have used and will ever be found among my prescriptions. I have tried it in two cases of trifacial neuralgia, after having tried some of our most powerful remedies, such as belladonna, opiates, quinine, gelsemium, arsenic, etc. None acted so well as Neurosine.

Editor "Memphis Medical Monthly."

Chattanooga, Tenn., Sept. 9, 1891.

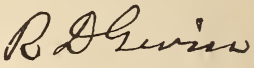
The completeness of the formula of Neurosine as displayed on the bottle at once attracted my attention. The sample was used and I must say the preparation has given better results and more universal satisfaction than any combination ever used by me. Have tried it in many nervous affections, in some it is a specific, in others a therapeutic agent of very great value.



Coroner Hamilton County.

McKenzie, Tenn., Feb. 12, 1891.

Neurosine had such a happy effect in a case of neuralgia or congestive headache in which I tried it, often having failed on other things of similiar nature. The case was one of long standing sick-headache of peculiar character. The lady, three days after confinement, without any fever, took severe headache. Neurosine relieved her immediately.



Stebbins, Va., March 8, 1892.

I have made fair trial of the Neurosine, and must say that it is in my hands the very finest neurotic I have ever used.

SAM'L HALES, M. D.

Ethridge, Tenn., March 23, 1892.

I gave Neurosine a fair trial in a case of neuralgia of the head and neck after a severe case of la grippe. It acted like a charm. Came up to all requirements.

C. D. HAMPTON, M. D.

Fourche Arcuault, Mo., March 18, 1892.

I sent about two tablespoonfuls of Neurosine to an old lady, aged 84 years; she had been complaining for some weeks with headache and neuralgic pains all over her body more or less. She took that small amount and has been quite free from pains ever since; went to church in a farm wagon 1½ miles, rough road, and is still free from pain, and sleeps and eats better. I am well pleased with it.

U. H. JOHNSON, M. D.

DIOS CHEMICAL COMPANY, ST. LOUIS MO., U. S. A.